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VOLUME 97 • NUMBER 1
JANUARY 1994

What's Ahead in '94:

Legislative Preview—page 12

A New Year's Resolve—page 16
Positive Thinking for Physicians

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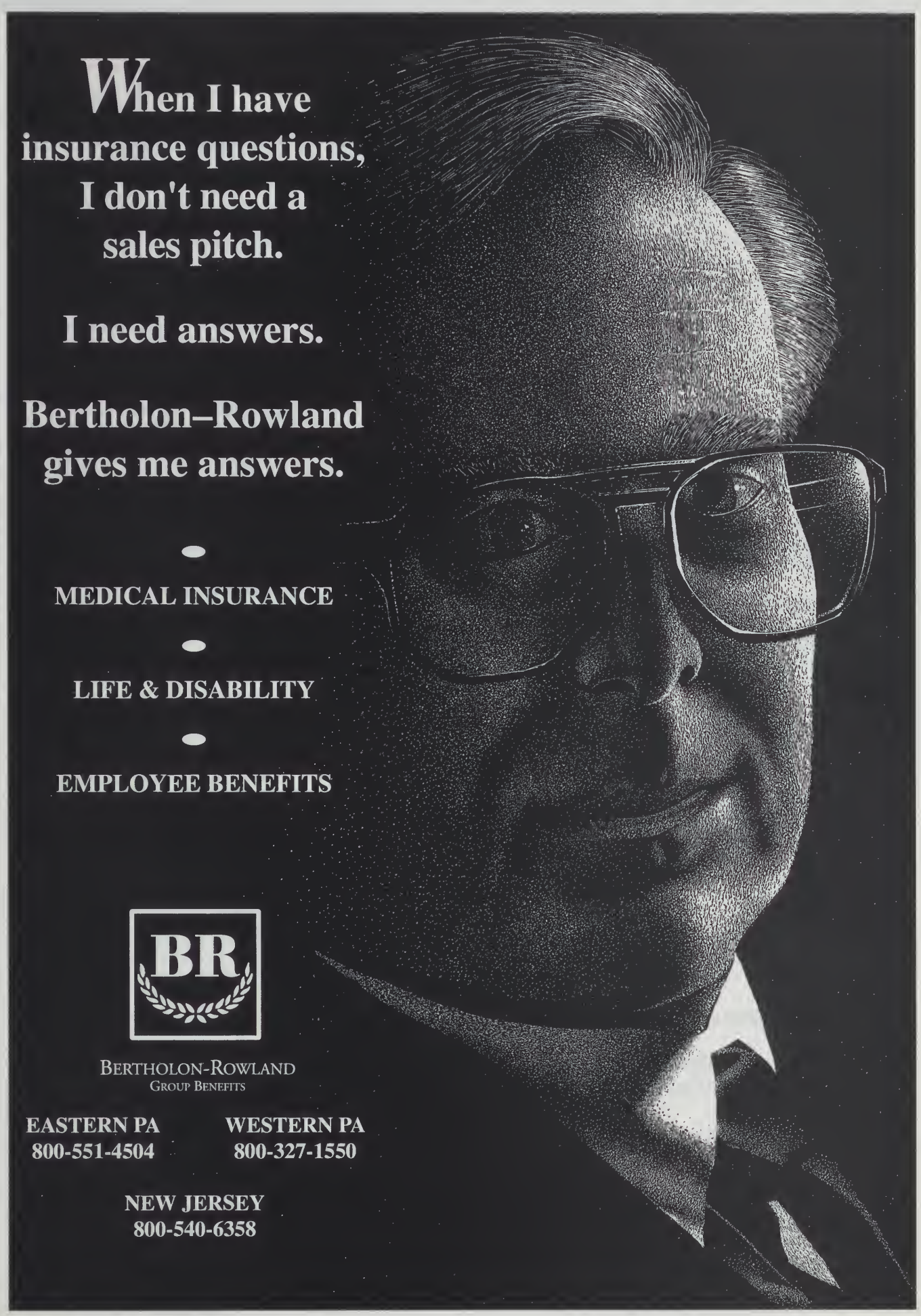
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Physicians Have a Place in the Political Process

Since instituting Medicare in the 1960s, government has played an increasing role in the practice of medicine. To maintain autonomy, the '90s physician must become involved—by keeping abreast of current legislation, and contributing time and resources to the political process.

Cover photo by Blair Seitz©, Harrisburg

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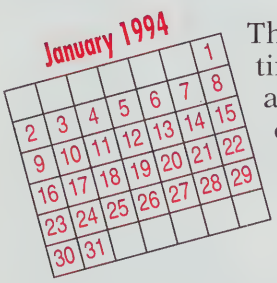

The move into 1994 will assuredly bring continued discussion of health system reform and changes to the profession of medicine overall. Yet, colleagues and statistics tell us, "Times are still good."

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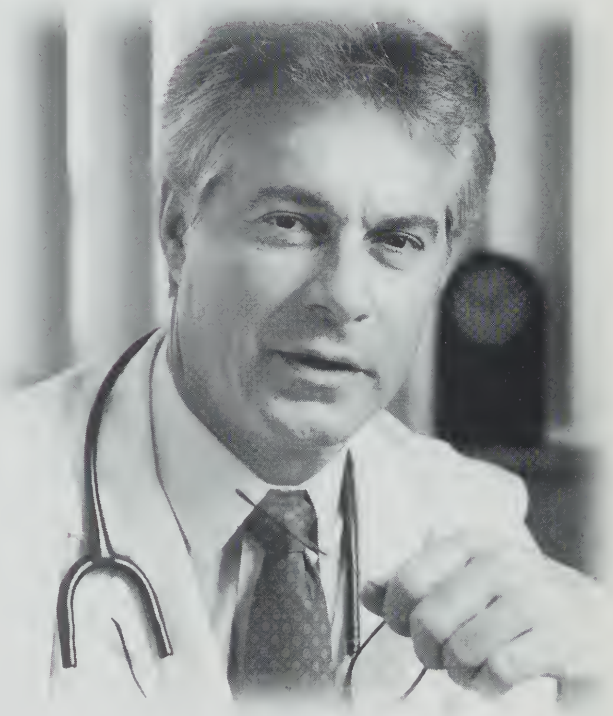
"Unfortunately,

he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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COMMITTEE TABLES HOUSE BILL 1497: The House Health and Welfare Committee in mid-December tabled by a vote of 12-5 House Bill 1497 which would mandate physician participation in a referral network for Medicaid patients. A week earlier the bill had been tabled by an 11-4 vote. The Society, while supporting the bill's intent to create referral networks for Medical Assistance patients, opposes language that would impose fines, licensure sanctions, and loss of hospital privileges upon physicians who choose not to participate. The Society says the current version of the bill would "negatively impact the effectiveness of voluntary [referral] programs that presently exist." The committee chairman may bring an amended bill to the committee for a third vote later this month. The Society will work to ensure that any amendments are palatable, and if not, will seek a "no" vote on the bill. For background, see page 13.

CLIA DEADLINE PASSES, NEW TEST CATEGORY PROPOSED: Physicians operating clinical laboratories at the moderate or high complexity levels are reminded that as of January 1 they must be enrolled in an approved proficiency testing program. Proficiency testing is also required at the physician-performed microscopy level when available. For additional information, call the Society's Department of Educational and Scientific Affairs at (800) 228-7823. In related news, the Health Care Financing Administration (HCFA) and Centers for Disease Control and Prevention (CDC) have proposed a final regulation to the Clinical Laboratory Improvements Amendments (CLIA) of 1988 which would establish a new Accurate and Precise Technology (APT) laboratory testing category as part of the moderately complex category. Although specifics are not yet available, the CDC says the category will include almost all testing equipment used in the physician office laboratory. No regular inspections will be required, although random inspections may occur. The comment period on the regulation was expected to begin this month.

AMA CLARIFIES REFORM POSITION IN LETTER TO PRESIDENT CLINTON: In a letter to President Clinton clarifying its position on financing health system reform, the AMA said it shared with the administration "common goals" for reform, including universal coverage, community rating, portability, administrative simplicity, and choice. The letter followed reports that the AMA no longer supported universal health care coverage, and explained that the AMA's expanded policy—adopted by its House in December and spurring the inaccurate reports—is "more flexible" and allows the AMA "to support integrating other approaches...with an employer requirement to achieve universal coverage."

SOCIETY DISCUSSES STATE REFORM WITH GOVERNOR'S STAFF: In anticipation of Governor Casey's return to work in December, the State Society met with his policy staff to discuss health system reform issues, including mandatory managed care and the basic benefits package. The administration indicated it did not intend to eliminate fee-for-service as an option and invited the Society to participate in discussions about how to develop a model benefits package. A report of those discussions was due to the Society's board at its January 12 meeting.

TRUST ANNOUNCES NEW EXECUTIVE DIRECTOR: The Society's Educational and Scientific Trust has named Matthew J. Tornambe, Mifflintown, as executive director beginning February 1. Tornambe will succeed LeRoy Erickson, who is retiring after 34 years of service to the Society. Tornambe comes to the Trust from the Central Pennsylvania Chapter of the National Multiple Sclerosis Society, where he was executive director for the past 10 years.

TWO PENNSYLVANIA RESOLUTIONS ADOPTED BY AMA HOUSE: Two resolutions presented by the Pennsylvania Delegation to the AMA on primary/ consultative care and proxy voting at medical staff meetings were adopted as submitted during the AMA's interim meeting in New Orleans in December. Look for detailed coverage of the meeting and delegation election results in the February issue of this publication.

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Wake Up: Let's Use Our Strengths

John W. Mills, MD
Medical Editor

As a trustee of the Pennsylvania Medical Society, I recently attended the AMA's Philadelphia meeting, "Physicians' Forum: Agenda for Action" (see page 30 for news story).

Although the attendance in Philadelphia exceeded that of the other two AMA regional forums held recently in San Francisco and Dallas, AMA staff were still perplexed as to why the turnout was so poor in Philadelphia. I think it's very simple: We physicians are sick and tired of all the rhetoric on health system reform, ranging from the Clintons' 4-pound-10-ounce, lopsided deal, to the proliferation of other health system reform papers.

"We physicians are sick and tired of all the rhetoric on health system reform."

Let's look closer at the Philadelphia experience. Saturday morning started out as an honest effort to host an array of good speakers. Representatives William Thomas (R-CA) and J. Dennis Hastert (R-IL) each contributed worthwhile information on how Congress will probably tackle the issue of reform and what the timeframe might be. Adequate audience question time with direct answers was a plus.

As lunchtime approached, however, we sensed that the afternoon's schedule would be an unknown, since the U.S. Senate was in a filibuster over gun control. Our country has matured considerably during its 200-year-plus history, but the Senate is lacking that same maturity in their childish ways. Politics? Baloney! I believe we should expect our senators to behave in a mature manner—forget the theatrics—when they are debating serious issues. That filibuster effectively wiped out the afternoon for the forum attendees. Obviously, this was not the AMA's fault.

The luncheon speaker couldn't have been worse—the room was half empty when Philip Lee, MD, second in command to Secretary Donna Shalala, finished. He spoke the party line to the point of absurdity. I suppose one shouldn't expect much from a physician who has been in government service since the Johnson administration.

It was all down hill from there. Louis Sullivan, MD, former secretary of Health and Human Services, spoke after lunch—a poor choice for a post-prandial audience. His answers were long-winded and circumventive. We didn't need this soporific.

The AMA, scrambling for fill-ins, put their board members who were present on a panel for questions and answers. It was sad to see the room gradually empty as the afternoon wore on.

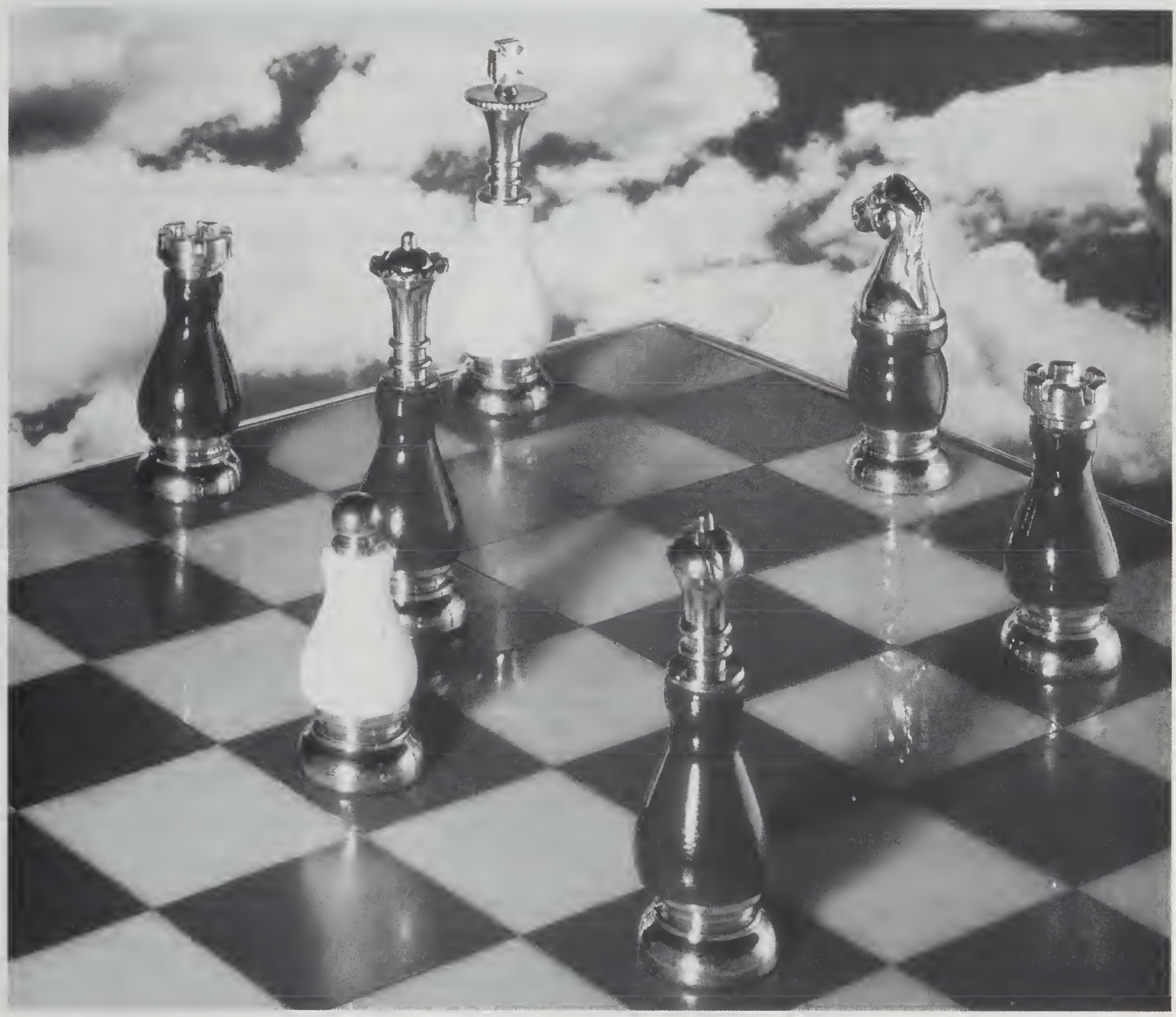
Sunday morning had three scheduled seminars. One was canceled for lack of registrants, but "When 60 Minutes Comes Calling" was quite successful, due in no small part to the AMA's Pat Clark and our own Amy Dugan, the Society's director of media relations.

I attended "Medicine in Transition—Strategies for Change." The main speaker got me off to a bad start by stating that "Medicine is no longer a profession—it's a business." I'll never be ready for that, and I hope you won't either. We aren't stupid; we know what a bottom line is; but we also know how valuable the doctor-patient relationship is, and if that goes, *everybody* loses.

The AMA tried hard to put on a useful conference, but we don't need to hear anymore rhetoric, and we can't waste anymore time—and money—attending this type of meeting. We need to get the word out to our patients back home STAT, and double time to our elected leaders.

We need action of the grassroots variety to help steer the course of health system reform. The problem is, we don't need to listen to the government's mouthpieces so much as we need to become mouthpieces ourselves. We can speak not only to the government reformers, but also to our patients—on their behalf. It's our only opportunity. The State Society and the AMA have developed materials to help us in this regard.

Wake up, AMA leaders! The federation of medicine has the biggest physician—and patient—audience in the nation. LET'S USE IT!



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A New Year Means New Work

Martin A. Murcek, MD

In observance of the new year, I would like to take a break from all the dismal concerns of health system reform and look at some of the more encouraging trends that bode well for the times ahead.

While we still have a long way to go, one trend that pleases me very much is the ever-dwindling acceptability of cigarette smoking. It seems every day there is a story in the news about some area or another being declared a smoke-free zone.

During the holiday shopping season, several malls in the Pittsburgh area banned smoking from all but small designated areas. Unlike Washington legislative mumbo-jumbo, this is a development that has an immediate, positive influence on the health of the public, and I applaud it. We still have to find ways to save smokers from themselves, but at least nonsmokers are being exposed to less second-hand smoke all the time. May this trend continue.

Another move in the right direction is government's stance—statewide and nationally—against "spiritual healing" as it applies to children. In the past, children have been denied timely, life-saving medical attention because their parents—religious fanatics—didn't believe in medical science and instead waited for some miracle while the child suffered and died. Often, no charges were brought against such parents, or the charges were dropped on the grounds of "religious freedom." Now, Massachusetts, Hawaii, and South Dakota have removed religious exemptions that shielded religious fanatics from being prosecuted for the outrageous neglect of their children.

Don't get me wrong, I feel that freedom of religious practice is one of the most important rights Americans have. However, that right cannot be allowed to supersede any American child's right to live, if it is in the power of medical science to help. Efforts to remove religious exemptions have failed in several other states, where politicians are hesitant to be seen as "messing with religious freedom," but this trend is catching on, and must continue.

A nascent trend, at least here in Pennsylvania, is one that deserves support from physicians: a renewed effort to change the destructive course of violent school-age children. A measure is soon to be offered by Pittsburgh City Council to establish a "boot camp" facility for youth offenders, as an alternative to traditional incarceration for acts of crime.

There are many hypotheses about the root causes of the increase in violent offenses committed by youngsters, but it seems reasonable that a return to strict discipline may be the best shot for some of these troubled young people at turning their lives around. I support—and I feel you should also—efforts to get these violent youngsters back on the right track. Boot camps, instead of the general prison population, seem like a good approach to follow.

There are some trends that need to be changed. Let me mention a few of them.

Despite the current Washington administration's continual grandstanding about caring for the health of all Americans, the typical government-subsidized school lunch still has almost twice the government-recommended fat content. Physicians need to pressure lawmakers to mandate lunches that are not only hot, but also healthy. Let's get on it.

Other than the occasional sensationalized story of an arrest or collegiate scandal in the newspapers, there is still little being done about steroid abuse by children and teenagers. While this problem was once confined to high school and college athletes, we are now seeing kids who aren't even athletes exposing themselves to the horrible destructive side-effects of steroids. If you have adolescents among your patients, be on the lookout for signs of anabolic steroid abuse, and tell all your young patients, male and female alike, that steroids are a disaster, and they should have nothing to do with them. Tell them to tell their friends at school, too.

A new year means there's new work to do. I wish you, your family, and your patients a happy, healthy, upbeat year ahead.

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Silent and Noisy Myocardial Ischemia
William W. Parmley, M.D.
Professor of Medicine
Chief, Division of Cardiology
Moffit/Long Hospital
San Francisco, CA

January 12th
Genetics of Cancer
Kenneth Blank, Ph.D.
Professor of Pathology
Department of Pathology
Hahnemann University

January 19th
JNC-V: Point and Counterpoint
Henry R. Black, M.D.
Roberts Professor and Chairman,
Department of Preventive Medicine
Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL

January 26th
Phospholipid Antibodies
Ann Parke, M.B.B.S.
Associate Professor of Medicine,
Division of Rheumatology
University of Connecticut Health Center
Farmington, CT

FEBRUARY 1994

February 2nd
Cardiac Pearls
Proctor W. Harvey, M.D.
Professor of Medicine
Georgetown University School of Medicine
Washington, DC

February 9th
Clinical Pathological Conference
Brian H. Fillipo, M.D.
Assistant Professor of Medicine
Director, Medical Residency Program,
Department of Medicine
Hahnemann University

Anthony Clay, D.O.
Chief Medical Resident
Department of Medicine
Hahnemann University

Jeffrey Hamilton, M.D.
Chief Medical Resident
Department of Medicine
Hahnemann University

Eliza Mandel, M.D.
Chief Medical Resident
Department of Medicine
Hahnemann University

February 16th
Pathogenesis, Immunity and Treatment of HIV Infection
Martin S. Hirsch, M.D.
Professor of Medicine
Infectious Disease Unit
Massachusetts General Hospital
Boston, MA

Bruce Walker, M.D.
Associate Professor of Medicine
Harvard Medical School
Infectious Disease Unit
Massachusetts General Hospital
Boston, MA

February 23rd
The Granulomatous Vasculitides
Gary S. Hoffman, M.D.
Chairman, Department of Rheumatic and Immunologic Diseases
Cleveland Clinic Foundation
Cleveland, OH

MARCH 1994

March 2nd
Impact of Nationwide Trials on Office Practice of Heart Disease
Robert Frye, M.D.
Professor of Medicine
Chair, Department of Internal Medicine,
Cardiovascular Consultant
Mayo Clinic, Rochester, MN

March 9th
Thyroid Nodules
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology and Metabolism
University of Massachusetts Medical School
Worcester, MA

March 16th
Peripheral Vascular Disease
Nicholas P. Tsapatsaris, M.D.
Clinical Instructor of Medicine
Harvard School of Medicine
Head, Section of Vascular Medicine and Hypertension
Lahey Clinic Hospital
Burlington, MA

David Naide, M.D.
Associate Professor of Medicine
Department of Medicine
Hahnemann University

March 23rd
Osteoarthritis: Diagnosis, Medical Management, Arthroscopy and Surgical Indicators
Vincent Zarro, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Rheumatology and Immunology
Hahnemann University

Arnold Berman, M.D.
Professor and Chair
Department of Orthopaedic Surgery and Rehabilitation
Hahnemann University

Albert A. Weiss, M.D.
Associate Professor of Orthopaedic Surgery and Rehabilitation
Hahnemann University

March 30th
Monotherapy of Hypertension
Barry H. Materson, M.D.
Professor of Medicine
University of Miami School of Medicine
Associate Chief of Staff for Education
Miami VA Medical Center
Miami, FL

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John Molavi, M.D.

MARCH 2, 1994
Office Management of Heart Disease for the Generalist
Course Director:
Leonard S. Dreifus, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair of Medicine, Director, Continuing Medical Education for the Department of Medicine

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LETTERS TO THE EDITOR

DROP THE LABELS, HELP YOUR PATIENTS

Now that the psychiatrists have declared premenstrual syndrome (PMS) to be a depressive disorder, the outrage of feminists is both predictable and understandable. Predictable because they do not want some normal women to carry the label of mental illness throughout life, and understandable because of the widespread confusion about what a disease, in fact, is.

The popular understanding of a disease is an entity of some sort to which symptoms are attached, much like the cabbage at a cocktail party which is never eaten and which is studded with toothpicks holding hors d'oeurves—thus, the common expressions like, "He caught a cold," and "He gave it to his classmates."

That notion of disease is wrong. A disease, per se, does not have any existence. All that exists are people with signs and symptoms. Clusters of signs and symptoms that occur together frequently have been given names for convenience. Thus, the occurrence of fever, cough, runny nose, red eyes, and rash is called measles.

Nosology, the systematic classification of diseases, comes only to this: a variety of what, in mathematics, is called set theory. A disease is a set whose members are the particular signs and symptoms that are assigned to it by definition.

In the case of PMS, the feminists have a point. The condition—premenstrual syndrome—already has a name, i.e., it is a set. Because a committee of psychiatrists found that some of the members of the set (symptoms) overlap with some of the symptoms they have (also arbitrarily) assigned to the sets they named Depressive Disorders, they want to include PMS under that rubric in their system. Actually, the symptoms they assign to depressive disorders are found in a host of perfectly normal people. It does no good, except perhaps to the egos of certain psychiatrists, to have people think their trouble is mental when, in all likelihood, it is chemical. If they knew their craft, they would drop the labels, recognize that there are only sick people, and apply their talents to helping them.

O.K. Stephenson, MD
New Bloomfield

KNOCKING OFF OUR WHITE HATS—AGAIN

Editor's note: Portions of the following are paraphrased from a letter originally addressed to Jean Brown, PharmD, associate professor of pharmacy at the University of Arizona and pharmacy editor of "Drug Utilization in Practice," a national newsletter "for physicians serving the Blue Cross and Blue Shield Federal Employee Program." It was submitted by the author for reprint in this publication. Percentages listed are derived from AARP survey data published in the newsletter.

Upon receiving the first "Drug Utilization in Practice" [October 1993], I offer these observations.

Prior to my entry into medical practice in 1976, I had accumulated 14 years of experience as both a hospital and retail pharmacist. I recall a "news item" proclaiming 10 percent or so of hospital admissions were due to adverse drug reactions, but I can't relate the source. The piece insinuated that prescribers were, essentially, to blame. I also recall the article did not detail the type of "adverse drug reactions," and I can only infer these were most likely pharmacologic extensions of activity (e.g., hypokalemia as a diuretic consequence), and although hardly acceptable, they were certainly not surprising and, for the most part, unpreventable.

An article in "Drug Utilization in Practice" takes another view, but promotes the same theme—the prescriber is to blame. This time, however, the problem is failure to use the medication. The article states: "Most [patients] have the ability to be compliant...Patients sometimes feel that they are wasting the physician's time if they want to discuss their medications. Or the patient may feel that he or she cannot tell the physician that the medication did not work as expected...Better communication between the provider and patient is essential to improving compliance." It seems that we physicians consistently have our white hats knocked off our heads whatever we do!

If the current crop of consumers who want to play a larger part in helping to direct and/or manage their medical care are serious, when are they also going to accept some of the blame for not paying attention, ignoring our advice, or simply failing to follow instructions? None of these are listed by the cited AARP survey as "common causes of noncompliance," but they certainly are not rare.

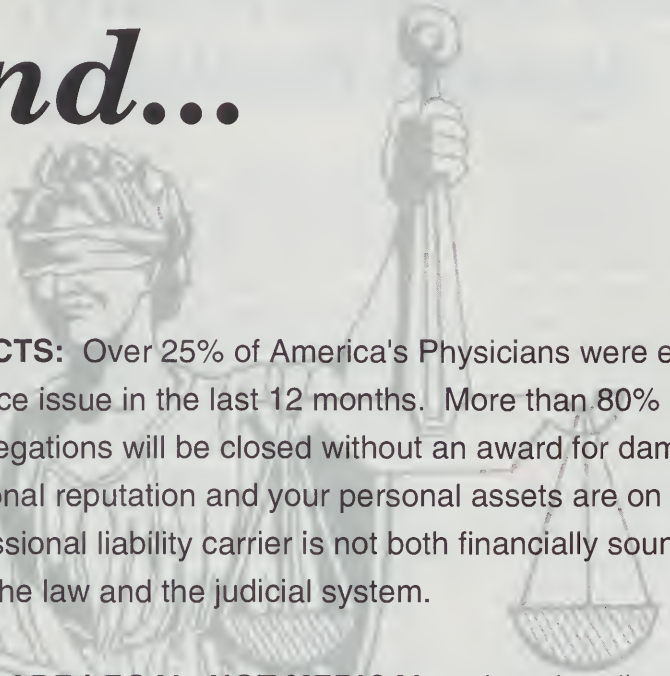
Many problems in medical practice today can be traced to consumer activists trying to help us do our job. They've succeeded in interjecting enough suspicion and mistrust into our patients to explain 94 percent of the AARP reasons for noncompliance.

I'm disappointed that the newsletter article didn't help point out that invariably one can lead the horse to water, but there is no guarantee it will drink. I offer a medical practitioner's view of the same reasons for noncompliance:

- *Concern about side effects* (30 percent): My 33 years of combined pharmacy and medical experience insist this song is getting old. "Side effects" are nothing more than rocks in the road to recovery that make the ride uncomfortable. They should not—but do—make the patient forget the disease being treated is far more dangerous than the side effects.
- *Thought the drug would not help* (31 percent): Obviously a failure of the patient, not the prescriber. In this case there is never a practical, let alone a factual or scientific basis, for making this error in judgment.
- *Condition improved* (21 percent): Reflects the microwave mentality of our culture. When the soup is done, turn off the heat; never mind keeping it warm for continued use. Just blast it with high heat when you want to eat it later. Same philosophy persists about hypertension, diabetes, hyperlipidemia, or any number of chronic diseases—in spite of what we preach.
- *Something read or heard* (seven percent): This generally falls into the "Dr. Gott says" category whereby if I don't agree with the newspaper article, I must be wrong. If I do agree, it confirms the patient's belief the visit was wasted.
- *Confused* (five percent): A natural consequence of exposure to the unsolicited advice by well-meaning friends, relatives, paraprofessionals, and the nightly news. I'm surprised it's not more than five percent.
- *Cost* (six percent): At this low level of influence, why are people traveling to Mexico for medications, and why are we trying to change the entire health care delivery system in this country?

Carl J. Forster, DO
Pottsville

...a promise to defend...



HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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Legislative Preview:

Reform Remains Priority, Agendas Developing

With remembrances of a most unusual 1993 behind them, and certainly with health system reform in sight on the horizon, the General Assembly faces a challenging and busy 1994 session. As an added attraction, it is an election year for all 203 House members, 25 members of the Senate, the 21 members of the U.S. House, and finally, for the governor and lieutenant governor.

As the first two-year session concluded in mid-December, there were already indications that 1994 would be a year of surprises. The keystone will most certainly be the developing political and election agendas at both the state and national levels. Those, in turn, will evolve as politicos from both parties make their personal decision to step up and challenge for higher office, or even step out and seek the quiet of private life.

The domino effect is a political reality in Pennsylvania. Congressmen Rick Santorum (R-Allegheny) and Tom Ridge (R-Erie) have already declared their candidacies for the U.S. Senate and governorship respectively. Their seats in congress will certainly look very inviting to some state legislators from their areas.

State Representative Ellen Harley (R-Montgomery) and state Senator Stewart Greenleaf (R-Montgomery) have already declared their intent to challenge first-term Democratic Congresswoman Marjorie Margolies-Mezvinsky. If they stay in the race, Harley and Greenleaf would not only leave their respective seats open, but may also make the political career decisions of other Montgomery County Republicans very difficult.

In November, State Senator Bill Lincoln (D-Fayette) announced that he will not seek re-election in 1994. His move out of legislative politics means that the internal fight for his position as the Senate Democratic (Majority) Leader will probably overshadow the primary election battle to elect his successor in the 32nd Senate district. It would take a master gamesman to properly line up all of the dominos.

In contrast, the political events during the first week of December were even more astounding. Just a year ago the State Capitol was still reeling from Senator Frank Pecora's change from Republican to Democrat, virtually in the middle of an afternoon Senate session. His decision tipped the balance of power in the Senate toward the Democrats. Now, two House members have made a similar switch, although this time moving from Democrat to Republican.

Representatives Ed Krebs (Lebanon) and Pat Carone (Butler) announced their decisions to change parties in separate press conferences held the first week of December. By December 7, the Democratic margin in the House had closed to 103-100. Although the Krebs and Carone switches had not handed Republicans control of the House—as Pecora had done for the Senate Democrats—the potential for a change of power was imminent.

To add to the power struggle, two Democratic legislators are expected to resign soon. Representative Bob O'Donnell (Philadelphia) is leaving to campaign for governor, and Representative Tom Murphy (Pittsburgh) has been elected Pittsburgh mayor. By the end of this month, Democrats are expected to have a slim 101-100 majority. The special elections to fill the O'Donnell and Murphy seats are expected to keep them in the Democratic column.

Recurring themes

For physicians and the State Society, however, the committee votes and floor fights on health care issues will continue to be far more important than the power struggle. Health system reform will be a dominant issue, although tax reform is also high on the agendas of many legislators for the year ahead.

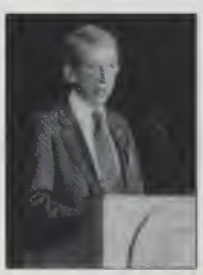
The one recurring theme surrounding health system reform is that legislators intend to act, but they are anxiously awaiting some sense of direction from the federal government. They recognize the issue is very serious and technical, and as a result are looking for a "once and done" shot at reform, which will probably come later rather than sooner.

Other legislative issues of interest to physicians and the Society will also be considered as the year progresses. From optometrists' use of therapeutic drugs, psychologists' continuity of care, physical therapists' direct access, and utilization review safeguards, to referral limitations, limits and rights of smokers, and HIV testing, the Society anticipates a busy legislative schedule in both the House and the Senate. Notwithstanding the myriad issues waiting in health reform, from insurance reform to quality of care, the normal press of medically related legislative business is not expected to abate. For example, a new bill has been introduced to remove the requirement that the secretary of health be a physician.

The Society as of this month had reviewed more than 3,500 pieces of legislation introduced by Senate and House members, and is actively lobbying on more than 250 bills! More bills are expected, some of which will hold great potential for a negative impact on the medical profession.

PHYSICIANS EXPRESS REFORM CONCERNS AT AMA FORUM

More than 400 U.S. physicians attended "Physicians' Forum: Agenda for Action," an AMA-sponsored meeting on health system reform,



Martin A. Murcek, MD (at left, top), president of the State Society, and Robert D. Reinecke, MD (at left, bottom), professor of ophthalmology, Jefferson Medical College of Thomas Jefferson University, Philadelphia, spoke at the AMA health system reform forum held in Pennsylvania in November. Dr. Murcek offered opening remarks, and Dr. Reinecke relayed his views of the health care industry.

held November 19-21, 1993, in Philadelphia. Four State Society physicians spoke at the forum, along with U.S. Senator Harris Wofford (D-PA) and other members of Congress, several government officials, and representatives of the AMA.

Coincidentally, the meeting was convened at the same time as the quiet introduction of President Clinton's health system reform bill—the main topic of discussion. The strongest fears voiced by physicians about the plan were: 1) it would hurt the current level of quality of care in the U.S.; 2) patient choice of physicians would be limited; and 3) government intervention would restrict physician autonomy. According to *USA Today* reporter Richard Wolf, "Finding boosters here [at the forum] of the Clinton plan...was nearly impossible."

Pennsylvania physicians speaking at the forum included: Martin A. Murcek, MD, State Society president; Donald G. Ferguson, MD, Society immediate past president; William S. Frankl, MD, Philadelphia County Medical Society president; and Robert D. Reinecke, MD, professor of ophthalmology, Jefferson Medical College of Thomas Jefferson University, Philadelphia.

The AMA sponsored two similar forums earlier in 1993 in San Francisco and Dallas.

Larry Light, the Society's director of legislative affairs, contributed to this page.

Physician Referral Networks Targeted:
A Warning and A Plea

House Bill 1497, a follow-up bill to achieve enforced access by Medicaid patients into physicians' offices, is troubling because of its heavy-handed, penalty-laden provisions. Sponsored by Representatives Allen G. Kukovich (D-Westmoreland), David P. Richardson Jr. (D-Philadelphia), H. William DeWeese (D-Greene), et al., it originated when House Bill 20 of the 1991-92 legislative session was transformed into a children's health bill, and the other parts of the original bill were resurrected piece-meal in the 1993-94 legislative session. As in House Bill 20, its approach is to require physicians to see "significant" numbers of Medicaid patients in their practice, but instead of tying it to licensure and fines for noncompliance, loss of hospital privileges and *big* fines for noncompliance are proposed.

The approach to establishing a system to ensure Medicaid patients' access has also changed. During the Society's participation in discussions about House Bill 20 in the past two years, 12 specific recommendations covering a wide range of access issues were proposed. One of those recommendations was to expand and improve physician referral networks (PRNs). The reasoning was:

- Almost all hospitals had physician referral systems in place to assure that patients seen in the emergency room would have access to follow-up physician care, inpatient and/or outpatient.
- Modernization of these existing referral systems through computerization and centralization, as had been done in a number of other states, seemed very feasible and would answer almost every alleged problem in Medicaid patient access to physicians' offices.
- Records of referrals and follow-up care generated by the computerized PRNs would for the first time give the Pennsylvania Medical Society hard proof of physicians' existing responsiveness for care of Medicaid and medically indigent patients. These records would also document patients who were "no-shows," physician shopping, and abusing the system—knowledge we will need in coming negotiations.

Representative Kukovich, et al., quickly seized upon PRNs as *the method* to assure Medicaid patient access to physicians' offices, clinics, etc.; but, instead of acceding to the Society's proposal to expand and modernize voluntary PRNs, the legislators incorporated into House Bill 1497 a mandatory approach with heavy penalties for non- or "inadequate" participation.

The Society will seek to defeat this bill or amend it to permit the Society to continue its program of establishing voluntary, physician-controlled PRNs throughout the state, and defer any mandatory system and penalties until, or in case, the voluntary PRNs are not effectively dealing with the problem.

Now, the plea! To strongly bolster the Society's position in coming negotiations with the legislature, we need to quickly and broadly expand the installation of computerized, physician-controlled PRNs beyond the current pilot programs into other areas of the state with a real or perceived access problem for Medicaid and medically indigent patients.

The systems, as installed by the Society from the individual hospital medical staff level to whole counties, have been successful with one caveat—they are so easy and quick to use that they have invited some abuse by overuse beyond the safety net for Medicaid/medically indigent patient access for which they are primarily designed. Because these systems are physician controlled, physicians can readily control overuse by simply paying attention to the PRNs' records of use and cracking down on individual physician members who try to use the system to inappropriately shift Medicaid/medically indigent patients or use the system to refer all such patients. Fortunately, such abuses have not been common, and the equitable distribution of Medicaid/medically indigent patients referred by the computerized PRNs is well liked by participating physicians.

Please consider looking into the Society's PRN system if your current physician referral system does not generate the hard copy data we need to show the legislature that voluntary physician-controlled PRNs can do the job without heavy fines and loss of clinical privileges mandated by the state!

For more information on what PRNs are and how they work, refer to "Helping the Medically Indigent and Underserved," in the February 1993 issue of PENNSYLVANIA MEDICINE.

The author, John A. Malcolm Jr., MD, a pathologist from Lewisburg, is a member of the Society's Task Force on Health System Reform and Access, and physician representative on the Pennsylvania Health Care Cost Containment Council.

PAMPAC: Advancing the Goals of the Medical Profession

Andrew W. Gurman, MD

The Pennsylvania Medical Political Action Committee (PAMPAC) has become a recognizable and effective organization in state and national political arenas. In this article, PAMPAC's chairman answers often-asked questions about the Society's PAC and political action committees in general.

In today's health care environment, government is an important part of the practice of medicine. Every medical decision that we make is shaped by current health care policy, from deciding which lab test to order for a patient, to making a referral for treatment or care of a patient. Because someone other than a medical authority is often influencing these medical decisions, it is more important than ever that physicians, as members of the medical community, take on the aggressive role of patient advocate. To be an effective force in government, you must become an active force in politics.

Why a medical political action committee (PAC)?

There are many special interest groups in the political arena, all vying for attention. As each interest group speaks out on its own behalf, only a unified force made up of physicians and their spouses can best represent the interests of the medical community and, most importantly, those of our patients.

The Pennsylvania Medical Political Action Committee (PAMPAC) is part of a national system of medical PACs. Joining PAMPAC offers each individual a convenient, time-effective means to become involved in both state and federal legislative races, and allows each physician to speak with a powerful, amplified voice.

PAMPAC works on behalf of the *entire* medical profession, enabling physicians to speak with one voice and expand the influence of the medical community in the increasingly complex political world. When you join PAMPAC, you also become a member of the American Medical Political Action Committee (AMPAC). In this way you are also involved nationally with the selection of candidates friendly to medicine.

Direct financial support is one of the most visible tools PAMPAC uses to represent physician and patient issues in the political arena. The PAC offers direct support to candidates running for state or federal office. Direct financial contributions, while an essential part of political involvement, are only the beginning. Financial support of a candidate *in conjunction with your personal campaign participation* make for a potent political power.

Whom does PAMPAC support?

Our highest priority is to support friendly incumbents. We seek to find and support friendly candidates in open races where no incumbent is in office, and we offer help to friendly candidates challenging unfriendly incumbents.

Decisions covering PAMPAC support for a candidate are made by its Board of Directors, composed of one physician from each of the 13 State Society councilor districts, five at-large physician members, and three Alliance (formerly called the Auxiliary) members. PAMPAC members may participate in the contribution decision-making process by contacting a member of the PAMPAC board, listed in the Society's "Resource Guide."

What is the purpose of PAMPAC?

PAMPAC's purpose is three-fold:

- to assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities;
- to promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs, and
- to encourage physicians and others to understand the nature and actions of their governments as to important political issues, and as to the records of office holders and candidates for election to office.

Dr. Gurman, an orthopedic surgeon from Altoona, is chairman of the Pennsylvania Medical Political Action Committee.

What does PAMPAC do?
The PAC's activities are varied, including identifying and contributing to friendly political candidates, as mentioned; sponsoring political education seminars; supporting State Society lobbying efforts; and working with the Alliance to identify and support individual political campaigns.

In addition to candidate support, our federal-level PAC, AMPAC, is extensively involved in data collection on voter demographics and opinions. Polls conducted for candidates include several questions on public health policy.

Why is PAMPAC essential to your practice?
Each and every member of the medical community benefits from PAMPAC's success. Decisions made within the political arena continue to have significant impact on the daily management of your practice. It is essential that you have an effective voice in influencing the outcome of those decisions. Today's health care environment may be in a state of flux, and the political environment might well be complex, but PAMPAC's goal remains constant: To advance the high standards and practices of the medical profession.

By law, all funds used for candidate support must come from personal contributions. Corporate checks may be used for educational activities only. Contributions to political action committees are not tax deductible.

Your PAMPAC contribution, membership, and subsequent participation in the political process are really an investment—in the medical profession, in your patients, and in the nation's health care system. *Your membership is critical. PAMPAC needs your support, and you need PAMPAC's active political involvement to protect your practice and patients.*

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Positive Thinking in a (Too Often) Negative Environment

Leif C. Beck, LLB, CPBC

With the uncertainty surrounding the future of medicine, we might fear that no one will be drawn to the profession; yet, statistics show that medical school enrollments continue to rise. In this article, we look at the choices, constants, and bottom line of joining the profession.

There is no question that medicine is changing rapidly. Physicians range between nervous and paranoid about the changing times, especially as they compare the new picture to their "golden era" of practice in the 1970s and 1980s. The sense of negativism among doctors is both pervasive and unfortunate.

Indeed, private practice may never again be as personally and financially rewarding as it was in those years gone by. Too many physicians react to the change with great frustration, making certain statements a common litany. We hear almost daily, "Medicine just isn't fun any more," and "I can't wait to get out of practice," and "I hope my children don't become physicians."

Still the best choice

But wait! We have heard these same comments for upwards of 10 years. The doctors making them have, by and large, continued to practice successfully beyond their—and our—expectations. If finances are the measuring device, our preferred barometers of successful practitioners' incomes continued to rise even into 1993.[1] The widely predicted income decreases seem to remain tauntingly just ahead, but, for most doctors, not quite yet upon them.

In the meantime, thousands of newly trained physicians have continued to enter the profession. They knew it would not be like it was in the '70s and '80s, but they chose medicine anyway. Medical school applications remain startlingly high because medicine is still the best career choice for many bright, capable people.

Pessimistic doctors too easily overlook the issue of choice. Would they trade places with their lawyer friends, preferring a profession fraught with self-doubt and turnover far beyond what we see in medicine? Or, with architects who are struggling to hold and keep their jobs in a 10-year building bust? Or, with their executive friends, whose industries—from manufacturing through banking—lay off capable people in their rampant "downsizing?"

In the larger picture, perhaps physicians' grass is less green until they look more critically at the other side of the fence!

Zero base change

We see the negativism more as a product of radical change in the health care system than as an absolute indictment of medical practice. But change is part of life. Both for individuals and organizations, things keep evolving; patterns once comfortable shift with time whether we like it or not.

Industries periodically undergo basic change. Such "zero base change" is necessary for an industry to remain effective as all about it changes. No one doubts that health care is in a zero base change period, and this obviously affects physicians.

Change is rarely comfortable. Few successful people would voluntarily put at risk what they know, and benefit by, in exchange for what is unknown. It is easy to think negatively in that environment.

And yet, since change is both inevitable and beneficial, it behooves us all to deal with it. Successful people welcome and manage change effectively, and doctors are now presented with that very opportunity. In fact, at a recent health care conference, a renowned clinic leader identified "Seven Propositions for Success" by relating them to change.[2] Four of them particularly relate to this article's themes:

- Change is learning—loaded with uncertainty.
- Change is a journey—not a blueprint.
- Problems are our friends—welcome and work with them.
- Change is systemic—it goes to the core of what you do.

Mr. Beck is founder and chairman of The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting, and founder and publisher of "the Physician's Advisory," a national monthly newsletter for physicians. He graduated from Duke University School of Law and is a former Wharton School of Business instructor.

"Art" or science?

Physicians object that the "old system" treated their patients best. On a one-to-one basis, that may be true. It overlooks, however, newer factors driving the reform movement. These factors are so powerful that they will not go away; we will have to adapt to them.

The most profound change is in the rapidly accelerating information flow. Medicine has been generations behind other disciplines in electronically developing and using data. Thus, physicians have been able to defend their patient care as part of the "art of doctoring," which was personally comfortable but technically uncertain. In this new era, computerized information systems may tell a physician that 99.4 percent of symptoms like his or her patient's indicated a certain condition, and that 81.2 percent of them had successful outcomes with a certain therapy. Though less "artful," such data will surely help physicians even more effectively treat their patients.

Computerized information technology also gives rise to sophisticated cost monitoring. The current annoyances of utilization review (both prospective and retrospective) are merely a phase as doctors and their physician-controlled networks move towards real synergy between their decisions, probable outcomes, and related costs. The way some large medical groups now study these relationships in setting treatment policies—like for angioplasties and PSA tests—shows that medical practice is constantly improving.

The old system allowed superb one-on-one care because someone else was paying for it. Since the mid-1980s, though, those "deep pockets"—primarily employers and government—have insisted on limiting their outlays. While their insistence fuels health system reform these days, it presents physicians with a whole new set of *opportunities* along with the burdens.

Several constants

With all this change, a natural part of life, there remain several constants. One is that the U.S. population continues to need physicians and their skills. The demand for diagnosis, treatment, cure, caregiving, and health maintenance will not go away, and it will always be physician-centered.

Doctors' business will thus not wither away, but will in fact grow. While physicians equate reform with lower reimbursement, incomes remain generally favorable, and new approaches, like capitation, offer new opportunities. No one, by the way, expects physicians to be less than among the highest of all occupations.

Another constant is that medical practice continues to be a unique way to combine technical challenge with service to others. While paying well, it provides personal activity deserving—and getting—respect which lawyers, bankers, and business people cannot even approach. With all the frustration of these changing times, the underlying reality of the physicians' role in society is the greatest positive of all.

The bottom line

Several years ago, a physician made this point clear in a guest article in *AMA News*. Richard E. Waltman, MD, said:

"Of course there are hassles, frustrations and problems. Every one of us has thought about quitting. But let's be honest: What could be more challenging, rewarding, and fun than practicing medicine? Drywall tapping? Arbitrage?"

"Even if things get worse, I am convinced that medicine will still be a most enjoyable vocation. The coming years will bring new difficulties, but also new challenges. Tell me how I can do a better job, face the future, deal with the problems, get more satisfaction. Don't suggest I give up."

"...For every four articles that tell me how badly I am doing, and how bad it will be, I want one that says how great it is to be a doctor. I also want at least one that reminds me to kiss my wife, hug my kids, smell some flowers, watch a hawk circle, and give thanks for all I have."[3]

And Pennsylvania's own famed former pediatric surgeon, C. Everett Koop, MD, summed it up so well in this very journal some eight years ago:

"I envy those starting a career in medicine. I regret some things that are going on—lack of good doctor-patient relationships, the preoccupation with money and power, the growth of regulation, and so on. But I also know that medicine still offers the individual one of the most satisfying ways to make a life that I have ever encountered."[4]

These are the real positives in an environment of exciting, though threatening, change.

"With all the frustration of these changing times, the underlying reality of the physicians' role in society is the greatest positive of all."

Notes and references

1. Those statistics are of the two national consulting organizations, the "SMD" and the "SPBC," although a few specialties—primarily ophthalmology, otolaryngology, neurology, and gastroenterology—finally started to decrease in 1992.

2. Wenzel FJ. "Seven Propositions for Success." Presented at Executive Forum on Physician Integration, sponsored by Quorum Resources, Inc., June 28-29, 1993.

3. Waltman RE. Let's boycott the 'gloom and doom' advice columns. *AMA News*, November 18, 1991, page 19.

4. Koop CE. Vocation in medicine challenges and satisfies. *Pa Med* 88(12):28-31, 1985.

NEW CABG REPORTS INCLUDE PERCENTAGES AND ODDS

The Pennsylvania Health Care Cost Containment Council's (PHC4's) physician-specific coronary artery bypass graft (CABG) surgery reports arrive this month with a few additions to both the Consumer Report and the Technical Report sections.

The reports are primarily based on 1991 CABG surgery data, but surgeons and hospitals will also see their 1991 data matched against their previously published 1990 data in the Consumer Report. The comparative data will include the number of patients treated and statistical rating of patient mortalities for each surgeon and hospital.

Additions to the Technical Report include percentages of mortalities of CABG surgery patients at each hospital (actual, expected, and risk-adjusted) to make the report's mortality statistics more readily understandable. There will also be a comparative analysis of in-hospital mortality related to the use of vein grafts versus arterial grafts versus combined vein and arterial grafts by each surgeon, surgical practice group, and hospital.

Both the Consumer Report and the Technical Report will list patient risk factors affecting in-hospital mortality, but with different approaches for explaining their impact. Not surprisingly, PHC4's 1991 CABG surgery research results showed that the significant patient risk factors correlated with increased in-hospital mortality for CABG surgery patients are:

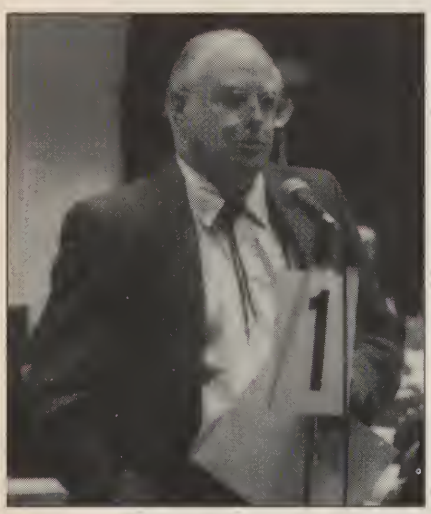
- increasing patient age,
- increasing severity of illness at admission,
- female gender,
- presence of cardiogenic shock,
- presence of congestive heart failure,
- presence of acute renal failure and/or renal dialysis dependency,
- presence of diabetes mellitus,
- history of recent acute myocardial infarction (less than eight weeks), and
- history of previous CABG surgery.

In the Technical Report, the average effect of each of the patient risk factors will be reported in the form of an odds ratio so that users of the data can better see how much, on average, each risk factor raises the odds of patient mortality when undergoing CABG surgery.

Aside from the above changes and additions, and inclusion of an explanation of how expected numbers of patient mortalities are determined, most of the reports' final format and text will closely resemble the 1991 data reports.

I suggest that each physician request a copy of the Consumer Report *and* Technical Report to get an idea of how and what they are about. There will be another physician-specific report in 1994, and it may well include you, depending on the medical diagnosis related groups (DRGs) selected as the subject of the report.

John A. Malcolm Jr., MD, Physician Representative, Pennsylvania Health Care Cost Containment Council



John A. Malcolm Jr., MD, physician representative to the Pennsylvania Health Care Cost Containment Council (PHC4), offered his expertise to the Society's House at its annual meeting last October.

For free copies of the Consumer and Technical Reports on CABG surgery, write to:

PHC4
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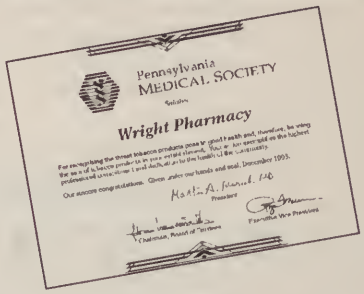
PHARMACIES RECOGNIZED FOR ANTI-TOBACCO EFFORTS



A recent statewide public opinion poll commissioned by the State Society revealed that nearly 60 percent of Pennsylvanians believe that those who smoke should pay more for their health insurance. The Society agrees.

The association has been involved in a number of public health projects to educate Pennsylvanians on the dangers of smoking and urge them to quit, including a program to recognize pharmacies which don't sell tobacco products.

In 1993, nearly 100 pharmacies throughout Pennsylvania were recognized, up from more than 60 pharmacies in 1992.

"It's hypocrisy," says Society President Martin A. Murcek, MD, a Greensburg allergist. "Pharmacies that sell tobacco products have shelves and shelves of products that, when used as intended, help people. Tobacco is the one product that, when used as intended, kills people...So, my hat's off to these pharmacies which have decided to sacrifice profits and do what is right."

Estimates are that smoking-related health costs are $22 billion per year. Lost wages and other expenses attributable to smoking add another $30 billion to the cost of smoking, putting the total estimated cost to the entire nation at $52 billion per year.

"It has been estimated that 80 percent of all patients we see in our offices are there because of 'self-inflicted' behaviors," Dr. Murcek says. "As a society we smoke too much even though we know the importance and value of being healthy. But many of us ignore what we know, and our health care expenditures reflect it."

For additional information about the Society's Tobacco-Free Pharmacies Program, call the Society's Department of Public Affairs at (800) 228-7823 or (717) 558-7750.

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Help for the Homeless: *One Town's Solution*

Gwendolyn L. Schultz

Family practitioner and certified addictionist William Santoro, MD, is medical director at both Albright College and the Reading Hospital Medical Center's Drug and Alcohol Detoxification Center. He also volunteers his time and medical services at the Reading Emergency Shelter, a homeless shelter in downtown Reading.

According to the Pennsylvania State Data Center, there are now 8,541 guests† in homeless shelters and 809 homeless persons on Pennsylvania's streets. Help for the Reading area's homeless began in 1984, when a small group of volunteers began roaming the basements of Berks County churches in search of shelter facilities to aid the homeless. After two years of shifting shelter locations, these volunteers established a public, non-profit organization, purchasing and renovating a downtown building on Second Street. The Reading Emergency Shelter opened its doors in the fall of 1987.

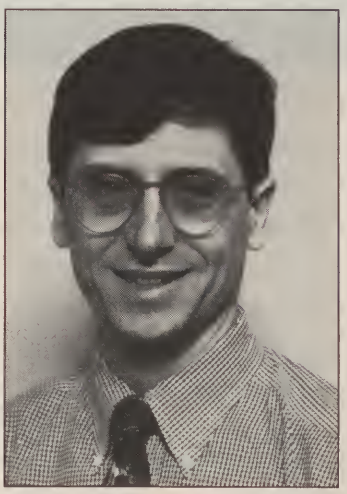
The homeless receive aid

Dr. William Santoro's first exposure to the homeless was in New York City. As he traveled the subways in the early mornings for his surgical rotation during medical school, homeless persons would often wish him well from their resting places in the corners of subway cars. After setting up his Reading practice in the early 1980s, he heard about the "migrating shelter" organized by volunteers and decided to volunteer what he thought would be most valuable—his time and skills. "Really," he says, "my time was more valuable than any money I could offer."

One evening he went to the area church which was serving as that week's shelter and asked the other volunteers if he could walk around and offer his services. He brought a stethoscope and blood pressure cuff to help those who needed medical attention. Another volunteer was also providing medical care, so the two decided to meet weekly and care for the homeless. As the needs grew, so did their efforts.

Medical services at the shelter

Dr. Santoro is now one of 10 physicians who volunteer time to administer basic medical care to the Reading shelter's guests every Wednesday evening on a rotation basis. Other physicians, including a pediatrician and an ophthalmologist, are "on call" to provide their services as needed. Dr. Santoro says, "It is nice to know that we have specialists available who will accept patients on referral in their offices with no charge to the patient. It is helpful because now we are not just an island in and of ourselves."



Dr. Santoro

A social worker is available daily at the shelter to set up medical appointments and complete a medical chart for patients. The worker records vital signs, history, and medications the patient is taking, and, if necessary, schedules a Wednesday evening appointment. Dr. Santoro has given the shelter permission to call him anytime in an emergency.

No controlled substances are permitted in the clinic, a policy which has been strongly publicized from the beginning to deter thieves from breaking into the shelter. But the lack of prescription medicine has not posed a problem for Dr. Santoro and the other physicians. Dr. Santoro says, "A lot of times I'll go to the cabinet and I'll say,

†*People who use the Reading shelter facilities are referred to as "guests."*

Ms. Schultz is assistant director of marketing and development for the Society's Educational and Scientific Trust.
This article is one in a series sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

'Now, I know what I want, but what have we got?' So it's a little bit of the M.A.S.H.-type of syndrome: You work with what you have and make the best of it."

He hopes the shelter will expand one day to include mental health and gynecological exams.

Guests are everyday people

As Dr. Santoro speaks of the homeless, he stresses that they are no different from anyone else. He recalls that one evening he decided to snap a few pictures of the staff and guests for a slide presentation he was giving. He asked permission to photograph a person whom he thought was a shelter guest, but discovered that the person was a staff member. He also decided to include a picture of his own children with the shelter's young guests in the presentation. "You couldn't pick my kids out from any of the other kids. Not just because my kids are naturally a little scruffy, but because they are just kids. The guests look like the staff members, and the staff members look like guests. They [the guests] look like everyday people."

Goals and hopes

The Reading shelter's goal is to get homeless persons back on their feet and back into the system. "This is ground zero here. We gather the pieces so that they can move on and put them all together."

When asked why he is involved with the homeless, Dr. Santoro says, "It makes me feel good, and I enjoy it. It also gives me a better perspective of why I got into medicine—to help people. I'd like to see others donate their time, and if not their time, then donate money to help the efforts. I think we have an obligation to help those in our society. If you want to see something happen, do something in your community. You'd be surprised at the impact you can make just by calling and saying you can stop by with a stethoscope!" ⬡

"You'd be surprised at the impact you can make just by calling and saying you can stop by with a stethoscope!"

—Dr. Santoro

Additional Facts About the Reading Emergency Shelter:

- Bill Sunderland is the shelter's executive director. The staff also includes a business manager, a coordinator of social and rehabilitation services, two social workers, an operations manager, a secretary, and 15 shelter employees who work during the evening to morning hours.
- The shelter has a capacity to house 100 men, and 44 women and children.
- The shelter is open from 5:00 p.m. to 8:00 a.m. from April 1 to October 31. During the coldest months of the year, November through March, the shelter is open 24 hours a day.
- There is a 30-day overnight stay limit for the six-month period from April to October. From November to March, staying time is unlimited.
- All equipment—including the beds, furniture, and medical supplies—is either used or donated.
- The center is not officially affiliated with any organization. The funds to support the shelter come from grants and contributions from a variety of local businesses, churches, individuals, and service clubs.

Services of the Shelter:

The Reading Emergency Shelter has five general services:

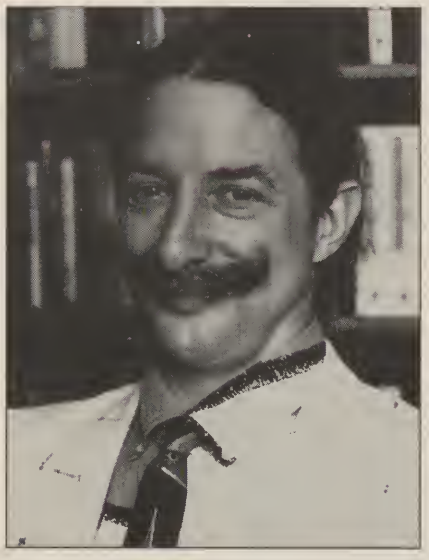
- *Emergency services for each guest*—Includes dinner and breakfast, a shower, laundry facilities, and a bed in a safe environment.
- *Medical services*—Basic medical assistance is provided with a limited supply of prescription medicine.
- *Social and rehabilitation services*—With the support of two full-time social workers, the shelter prepares the homeless guests for independent living.
- *Day programs*—During the coldest days of the year, November 1 to March 31, education services, recreation projects (arts and crafts, video games, etc.), and service programs are offered.
- *"Homeward Bound"*—Offered for guests who are ready for independent living. A sponsor supports the individual by providing the first month's rent on an apartment, furniture, bedding, and kitchen utensils. The individual must have secured employment before entering the program to ensure that he or she will be able to continue the rent payments after the sponsors' support ends.

A Pie in the Face of Greed

Fred D. Baldwin

Though every physician has his or her own way of treating patients, Hunter D. "Patch" Adams, MD, has an approach all his own: He uses clowning to break the barriers of practicing medicine. In a recent Central Pennsylvania appearance, Dr. Adams discussed his approach, as well as the importance of compassion in medicine.

You'd notice Hunter D. "Patch" Adams, MD, even if he weren't on a speaker's platform. He stands six feet, four inches tall, sports an upturned handlebar mustache, and ties his almost waist-length ponytail with rubber bands. A minute or so into his remarks, he takes off his jacket to give the audience a better look at his shirt and tie, a kaleidoscopic flash of Day-Glo colors. Then, after a few semi-solemn remarks about endorphins ("for the doctors who're getting CME credits for this"), he takes off his shoes and pants, revealing a pair of billowy pink bloomers.



Dr. "Patch" Adams

Warming to his work, Dr. Adams soon pops on a rubber nose and a hat topped with a rubber duck. He urges the doctors in his audience to try wearing their underwear *outside* their suits and to ponder the therapeutic merits of whoopee cushions. In the pauses between laughter, he talks about why he treats patients for free, about why he doesn't carry malpractice insurance, and, repeatedly, about the importance of compassion in medicine. "The true reward in medicine," he says, "isn't money or awards. It's the ecstasy of human intimacy we get with a patient."

Dr. Adams, who sees clowning as an integral part of his practice of medicine, spoke in Harrisburg in October on "Humor in Health Care." The audience was a group of 270 doctors and other guests attending the second annual dinner symposium honoring the memory of Frederick D. Curcio III, MD, sponsored by the Department of Obstetrics and Gynecology, Harrisburg Hospital.

"I have spent all my adult life misbehaving," Dr. Adams says, as he describes his evolution into what one publication has called the "Court Jester of Modern Medicine." He says his father died when he was 16, and a few years later, an uncle who had become a surrogate father committed suicide. After he himself had made a suicide attempt, he arranged for his own admission to a mental hospital. There he met patients far more lonely and depressed than he and "decided to spend the rest of my life as a joyful person."

After graduation from the Medical College of Virginia, Richmond, in 1971, he and a group of like-minded rebels against what he describes as "medicine as a business" founded a communal health care center in which medical doctors, nontraditional practitioners, and their families ("20 adults and two children") not only worked together under the same roof, but shared meals and shelter with patients. The center, ultimately christened the Gesundheit Institute, dispensed medical services free of charge, declined third-party payments, and carried no malpractice insurance. The staff survived by jobs and from donations, including gifts of food and services.

Despite a grueling schedule and almost total lack of privacy, no staff member left the center for nine years, says Dr. Adams. The group still enjoys remarkable stability and manages to avoid staff burnout. "Why is that?" Dr. Adams asks. "We are *fun* to play doctor with. We created the first silly hospital in history."

In a recent book, *Gesundheit!*, Dr. Adams writes that malpractice insurance is unnecessary when patients think of a

Mr. Baldwin is a freelance writer from Carlisle.

doctor as a specially trained but fallible friend who is doing his or her best to help. He also insists that both malpractice insurance and third-party payments create unnecessary distance between doctors and patients.

Asked about health system reform, Dr. Adams says that the reforms he has in mind are more fundamental than changes in delivery and payment systems. "The scariest thing about Clinton's package, if it passes, is that we'll say, 'Well, we've covered that problem. Now on to something else.' The health care delivery system is in shambles. There's not a happy hospital in this country. Medicine has the potential to bring a community together. People need to donate a significant amount of their free time to the community. It is an embarrassment to think the bottom line has anything to do with it. I want to be a pie in the face of greed."

"If the society were the patient and came to us, and we looked at the quality of life, the drug-use rate, the violence rate, and all those other rates, we'd say we've got an ICU case here. We are in a state of emergency, and the patient is the planet—our planet. We need a grassroots recreation of the human community, and humor is one of our tools."

In between comments like this, Dr. Adams puts a pair of jockey shorts on the head of a woman in the audience. He suggests to the doctors present that holidays would be a good time to experiment with wearing their own underwear on the outside as they make their hospital rounds or consult with patients. "You don't have to start with underwear," he tells a questioner. "If this seems too radical, on Arbor Day put a plant on your head."

Dr. Adams's audience stops laughing when he describes a Russian child with third-degree burns over 65 percent of his body, screaming with pain because his dressings had to be changed in a hospital that lacked anesthetics. Dr. Adams, embodied by his gentle but physically grotesque clown character, spent an hour-and-a-half at the child's side during the ordeal. Afterwards, the child whispered, "You're beautiful!" Dr. Adams says, "After I got on the bus, I broke down and sobbed for a very long time."

Such abrupt shifts between slapstick and seriousness seem natural, rather than jarring. In print and in person Dr. Adams comes across as a sophisticated man who understands perfectly well that not everyone shares his values, but who is convinced that to trade laughter for respectability is to strike a fool's bargain.

His own permanent clown *persona* is an innocent, or, as Dr. Adams puts it, "He's just too simple to understand, 'We don't do that.' " Dr. Adams settled into this character after a period of work with profoundly retarded adults and experiencing "their unconditional love." He has carried this second identity as a "holy fool" (a notion found in the classical Russian novels he admires) into hospitals and across national borders.

"I've gone up to Soviet policemen and taken off their helmets, put rubber noses on their faces, and then put their helmets back on. I've run that character for 10 or 12 hours at a stretch without getting out of it, and by the end of that time I don't want to."

To an objection that antics like his could cause patients to lose confidence in their doctors, Adams responds: "If you have compassion and sympathy, and your patients love you, you have no idea what you can get away with. I have gone to a dying patient's bedside dressed as an angel with a harp...and a sign saying 'Coming Attractions.' But I didn't do that as a stranger."

Dr. Adams, through lectures and sales of his book, raises money for a reincarnation of the Gesundheit Institute as a 40-bed free hospital in Pocahontas County, West Virginia, built around the message, "Good health is a laughing matter." It's clear that he believes that.

"Suppose," he says to his Pennsylvania audience, "you're being admitted to a hospital and have a choice between a 'Serious and Solemn Ward' and a 'Goofy Ward'...How many of you would choose the goofy one?" All around the room, hands go up.

"Higher!" Dr. Adams shouts. "Higher, so the administrators can see!" He shakes his head and says softly, almost as if to himself, "Almost everyone wants that, why don't they try it?"

Then, firmly: "I'm not really talking about rubber noses and big shoes, but a twinkle in the eye and a willingness to greet the world with a big hello. One of the most revolutionary acts you can commit in this society is to be publicly happy." ⬡

For additional information about Dr. Adams and his work, contact him at:

Gesundheit Institute
6248 N. Washington Blvd.
Arlington, VA 22205
(703) 525-8169, FAX (703) 532-6132

"I'm not really talking about rubber noses and big shoes, but a twinkle in the eye and a willingness to greet the world with a big hello. One of the most revolutionary acts you can commit in this society is to be publicly happy."

Medical Editor's Note: Hearty agreement with this—it's the secret of enjoying medical practice!

HCQII: Focused Review Enhances Analysis Efforts

Donald E. Harrop, MD

Because the Health Care Quality Improvement Initiative (HCQII) is so important to the new direction of the Keystone Peer Review Organization (KePRO), and because it represents such a departure from previous PRO activities, we will devote this page, over the next few months, to explaining some of HCQII's major components. This month we look at focused medical review.

As part of our new direction under the Fourth PRO Scope of Work, the Keystone Peer Review Organization (KePRO) has placed a new emphasis on data analysis and educational feedback to physicians and hospitals through its Health Care Quality Improvement Initiative (HCQII). One of the most important components of HCQII is focused medical review.

Focused medical review is completely different from what we called "intensified review" under previous PRO contracts. Focused medical reviews are used when there are medical conditions or procedures suspected of having variations in medical care delivery and/or outcomes. They may be used during the development of cooperative projects or as a part of pattern analysis, or they may be limited to the suspected variations in care, i.e., not requiring a "full menu" review such as necessity of admission, coverage, diagnosis related group (DRG) validation, etc.

Some HCQII cooperative projects are initiated based upon recommendations of the KePRO Steering Committee (formerly called the Master Committee) which provides advice to KePRO staff. A recommendation usually involves a particular medical condition or procedure that will improve medical care. A study group would then be formed comprised of professionals from throughout the state, KePRO staff, and three assistant clinical coordinators. Our assistant clinical coordinators are all academic physicians, each of whom holds a position as assistant professor at a university medical school in Pennsylvania.

KePRO staff may analyze Health Care Financing Administration (HCFA) analytic file data, KePRO claims data, and/or KePRO review data to investigate these particular issues. Claims data analysis may be enhanced by focusing medical reviews on those cases that appear to indicate use of a different process or result in outcomes unlike those of most other physicians and/or hospitals. This is not to say that different is necessarily bad. In fact, their process and outcomes may prove to be superior to those of most of the physicians and/or hospitals in the state. These are frequently referred to as "benchmark practices."

The next step is one of the more difficult jobs in the HCQII process—taking information learned from the study, communicating it to the provider community, and, of course, discussing it with those aberrant providers whose treatment process and outcomes are less than desirable, to help them better understand their practice and to work with them to provide more effective treatment.

Another important task is to get hospital medical staffs and administration to work together to solve any problems which may have been discovered from the study. This is done in a variety of ways, including onsite visits to hospitals by our principal clinical coordinator, assistant clinical coordinators, and/or KePRO staff; regional seminars; publications; and any other opportunity we may have to provide educational feedback to providers. Examples of publications that will be used are the "HCI Newsletter" and KePRO semi-annual reports. Both publications report on projects in progress and results of completed studies.

With less than a year of experience in HCQII activities, we are still in the learning process because the entire concept is relatively new. But that's part of what makes it so exciting, knowing the tremendous potential for improving health care delivery if we work hard and can get the cooperation of the medical community.

Dr. Harrop is president of the Keystone Peer Review Organization.

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HCFA RELEASES 1994 MEDICARE CHANGES

The Health Care Financing Administration (HCFA) in late November 1993 released a fact sheet outlining changes in Medicare reimbursement for 1994.

As always, increases to the physician fee schedule reflect the OBRA '93 mandated reductions from the default update, which is based on inflation and performance under the Medicare Volume Performance Standard (MVPS). The following increases were released for 1994: 10 percent for surgical services, 7.9 percent for primary care services, and 5.3 percent for other non-surgical services. No inflation update has been made for ambulatory surgical centers.

Other changes include:

- reinstatement of separate payment for EKG interpretations;
- reduction of certain practice expense relative value units;
- repeal of new physician and practitioner payment reduction;
- a cap on payment for medically directed anesthesia services;
- expansion of the participating versus nonparticipating payment differential to drugs and to non-physicians;
- expansion of the limiting charge to drugs and to all services/supplies billed under the physician fee schedule regardless of the billing entity;
- new annual caps for physical and occupational therapy;
- reduction in payments for clinical laboratory services;
- fee schedule payment changes for durable medical equipment (DME), prosthetics and orthotics, and surgical dressings;
- new coverage for oral cancer drugs;
- coverage of "off-label" uses of anti-cancer drugs; and
- expansion of coverage of certified nurse midwife services.

Physicians who did not receive a copy of the fact sheet should contact their local Medicare carrier.

SOCIETY PURSUING STATEWIDE MEDICARE CHARGE CLASS

In October 1993, the Society's House of Delegates approved a resolution calling for the State Society to petition the Health Care Financing Administration (HCFA) for a single statewide charge class for determination of Medicare payments to physicians.

As a result, a petition requesting that Pennsylvania's current four localities be converted into a statewide locality is being prepared by the Society. The Society intends to file the petition by the end of January, a month prior to HCFA's deadline, to ensure ample time for consideration.

HCFA has stated that it will consider this type of request only if there is "overwhelming support" among the physicians in the state. The Office of Payment Policy (OPP), the unit within HCFA responsible for reviewing statewide locality petitions, has a number of requirements, including a list of the number of actively practicing physicians in the state by county and the number that are State Society members, and letters of support from the local societies which represent physicians who will experience a decrease in reimbursement under the proposed change. Optional letters of support are also accepted from specialty societies, medical schools, multi-specialty providers, legislators, and the Medicare carrier.

To date, only five states have been converted to a statewide locality—three (Minnesota, Oklahoma, and Nebraska) by legislative action, and two (Ohio and North Carolina) by regulatory action. HCFA has denied the petitions of Iowa, Oregon, Washington, and Wisconsin for lack of "overwhelming support," and in each case cited lack of support from physicians who would experience reimbursement decreases.

BILLING PACKAGE FREE TO MA PROVIDERS

EDS, the contractor for the Pennsylvania Medical Assistance (MA) program, has developed a new software package which it says will ease claims submissions for MA providers. Known as National Electronic Claims Submission (NECS), the package is free to MA providers.

Physicians with an IBM or compatible personal computer and a DOS operating system may use NECS to submit claims either by modem transmission (claims may be sent to EDS 24 hours a day, seven days a week) or mail-in diskette (data is submitted to the Department of Public Welfare for processing the same day it is received by the contractor).

Features of the package include:

- user-friendly data entry screens for all invoice types;
- help screens and tables that are interactive to improve ease and accuracy;
- provider, patient, diagnosis, and procedure code reference files which can be easily updated and allow physicians to "plug" data into the invoice fields;
- reporting for easy claim tracking and reconciliation;
- automatic backup for claim and reference files; and
- security features to provide protection of provider claim data.

EDS is also offering its Reformatter service to MA providers free of charge. The service allows physicians who use a computer system to track claims and who also submit hard copies of claims to send data to EDS for reformatting for electronic submission.

For further information, call EDS at (717) 975-6001.

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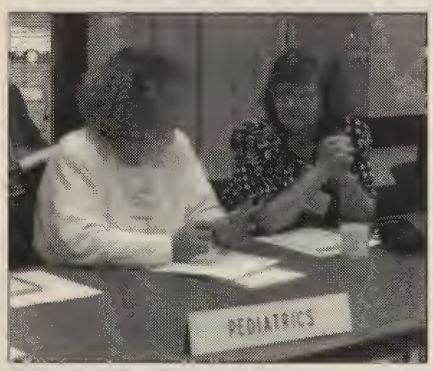
Specialty Task Force Aims at Partnership

As a result of a first-of-its-kind roundtable at Society headquarters in December, a task force with representatives from family practice, internal medicine, medical specialties, and surgical specialties is being formed to determine the best way to build effective partnerships between the State Society and specialty organizations on physician-initiated managed care strategies.

At the roundtable meeting, John Gannon, partner-in-charge of KPMG Peat Marwick's National Health Care Management Consulting Practice, presented a summary of findings from the study commissioned by the State Society to identify ways the Society can assist physicians as the influence of managed care increases in Pennsylvania. The more than 50 physicians and guests in attendance also participated in an open discussion session.

Participants generally agreed to support the development of a management services organization (MSO), and are creating the task force to report on how specialty societies and the Society could act as partners in the MSO. The task force will report to the Society steering committee, charged with the formation of a for-profit subsidiary.

Twenty-four specialties were represented at a rountable meeting on physician-initiated managed care strategies sponsored by the Society in December. Pictured are representatives of nuclear medicine, ophthalmology, orthopedic surgery, and otolaryngology.



Suzanne Yunghans (left), administrator of the Pennsylvania Chapter of the American Academy of Pediatrics, talks with Wilma Kellerman, MD (right), specialist in physical medicine and rehabilitation, during a gathering of specialty representatives at Society headquarters last month.

SOCIETY RELEASES 1993 PUBLIC HEALTH POLL

The Society's 1993 Public Opinion Poll, released at a news conference, focused on insurance and bioethics issues related to health system reform.

Society President Martin A. Murcek, MD, said the survey "explored tough questions at the heart of the health care debate that have not had the same scrutiny—questions that confront our basic beliefs on the importance of human life."

He emphasized that one of the Society's greatest concerns about some health system reform proposals is that they may limit the ability of people to choose their physicians and their coverage.

The poll showed that 72 percent of Pennsylvanians believe people should have the ability to choose from several basic benefits packages to meet their needs. And 86 percent said that people should be allowed to purchase supplemental insurance to cover medical services that might not be included in the basic benefit package offered under a particular reform plan.

Another Society concern is that reform may create more of a bureaucracy that takes away the ability of patients and their physicians to make the best medical decisions for the patients.

"There are a number of things wrong with our health care delivery system, but there are also those things that are right," Dr. Murcek said. "The doctor-patient relationship is one of the things that is the most right and one which reform shouldn't take away."

He noted that the survey showed that Pennsylvanians prefer a health delivery system focused on individual and personal relationships, as opposed to institutional decisions. He said it was most evident in the responses to questions where physicians would make decisions that limit care. For example, nearly two-thirds of Pennsylvanians still believe that a physician should be permitted to help end the life of a terminally ill patient.

"I think this points out the desire of people to make medical decisions in cooperation with their physician and not have those decisions dictated by a bureaucracy," Dr. Murcek said.

More extensive results of the survey were published in the December 1993 issue of PENNSYLVANIA MEDICINE, pages 38-39.

COUNTY NEWS

PHILADELPHIA COUNTY HONORS MEMBER PHYSICIANS

The Philadelphia County Medical Society (PCMS) on November 7, 1993, honored outstanding members of the Philadelphia medical community during its annual "black-tie-preferred" Awards Night, held this year at the Adam's Mark Hotel.

The highest honor of the evening, the Strittmatter Award, was presented to Edward S. Cooper, MD, for his commitment and outstanding contribution to Philadelphia medicine.

Dr. Cooper, a native of South Carolina, graduated first in his class from Meharry Medical College School of Medicine, Nashville, Tennessee. His Pennsylvania career began with an internship and residency at Philadelphia General Hospital.

He then served two years in the Air Force, but returned to the commonwealth as a National Heart Institute fellow in cardiology at Philadelphia General. After being certified in internal medicine, he remained as an attending physician at the hospital.

Throughout the years, Dr. Cooper also worked at Mercy-Douglas Hospital, and served as associate in and professor of medicine at the University of Pennsylvania School of Medicine. Since 1964 he has been an attending physician in medicine at the Hospital of the University of Pennsylvania. He has published more than 50 papers, many on hypertension and stroke, and served on the editorial boards of the *Journal of the National Medical Association* and *Stroke*. William Weiss, MD, a Philadelphia specialist in pulmonary diseases who has known Dr. Cooper since his internship, says Dr. Cooper is "an admirable physician and gentleman whose accomplishments merit [this] highest honor."

The Cristol Award for contributions to the county society's educational, scientific, and charitable goals was presented to Raymond Lodise, MD, a native of Philadelphia. Dr. Lodise specializes in internal medicine and cardiovascular diseases, and is active in the treatment of addictive diseases. He is an attending physician in the Department of Cardiology at Graduate Hospital, director of two treatment centers for addictive disease, and medical director of Continental Bank. Dr. Lodise has been an active, highly visible member of organized medicine since 1960.

Several other physicians and community members were also honored:

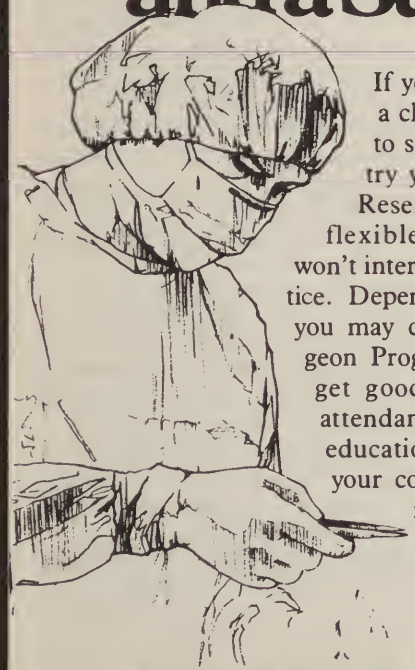
- Edward Gottheil, MD, professor of psychiatry and human behavior at Jefferson Medical College, received the C. Nelson Davis Award for excellence in research devoted to educating physicians regarding addictive disorders afflicting physicians.
- Charles R. Shuman, MD, emeritus professor of medicine, Temple University School of Medicine, received the Krasnoff Award for the Practitioner of the Year for dedication in the area of patient care and community service.
- Sara B. Kinsman, MD, Robert Wood Johnson Foundation scholar, University of Pennsylvania School of Medicine, and Michael P. Moulton, MD, senior resident in emergency medicine, Medical College Hospital, Main Clinical Campus, each received the Humaneness in Medicine Award for Resident Physicians for their skill in working with people and understanding human, as well as clinical, needs.
- The Breast Health Institute, a group whose major goal is fundraising to support worthy projects in all areas devoted to the eradication of breast cancer, received a Benjamin Rush Award for outstanding voluntary contributions to the health and welfare of the people of Philadelphia.
- Donna Howley, a Philadelphia City worker, also received a Benjamin Rush Award for work with and commitment to the city's child abuse services, including the Child Abuse Hotline.

YOUNG PHYSICIAN SECTION NEWS

NOMINATIONS SOUGHT FOR COMMUNITY SERVICE AWARD

The American Medical Association Young Physician Section (AMA-YPS) is accepting nominations for the its 1994 Community Service Award. The section represents physicians under age 40 who are no longer residents or fellows, or any age if within the first five years of professional practice. The annual awards program strives to recognize and encourage excellence in community service activities led by young physicians. →

An Officer and a Surgeon



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Community service activities implemented as a medical society project or by individual young physicians may be nominated. That would include, but not be limited to: medical/legal clinic for the homeless, a natural ambassador project, monthly health education cable TV show, pre-participation sports examinations for needy children, sample pharmaceuticals donated to clinics for the indigent, drug abuse prevention programs, volunteer activity at an AIDS clinic, involvement in medical missions to other countries, or flood/hurricane relief projects. The activity must have occurred during 1993 or 1994, or the individual must demonstrate a commitment to significant community service over a lifetime.

The AMA-YPS Governing Council will select award recipients based on:

- positive effect on a community or population;
- thoroughness of a program/project planning and implementation, and
- completeness/comprehensiveness of information submitted.

Depending on the number and quality of the submission, more than one award may be given.

Presentations will be made during the AMA-YPS Assembly on June 10-11, 1994, at the Chicago Hilton & Towers.

For additional information and official nomination forms, call the AMA Department of Young Physician Services at (800) AMA-3211. Entries must be postmarked by April 1, 1994.

NEW GRANT TO EXPAND CARE FOR UNDERSERVED

The Robert Wood Johnson Foundation (RWJF) is accepting applications for its new "Reach Out" program, which will provide up to $14 million in grants to organizations to develop and implement projects to expand the role of private physicians in caring for the medically underserved.

The program is open to organizations representing practicing private physicians, including local and state medical and specialty societies, large group practices, and hospital medical staffs that include office-based attending physicians. Applicants are encouraged to develop sustainable projects in line with community needs, resources, and local tradition. Target populations might include the uninsured, underinsured, or Medicaid enrollees, as well as special populations.

The program will consist of one-year developmental grants of up to $100,000 each to support projects in 40 to 50 communities. Grantees will then be eligible to receive three-year implementation grants that will average $200,000. While the funds may be used for a variety of support and start-up activities, they may not be used to pay physicians' fees.

For additional information and a grant application form, call H. Denman Scott, MD, MPH, at (215) 351-2740. Deadline for applications is March 14, 1994; recipients will be announced in August.

Thirty-two physicians and other health care workers attended "Tuberculosis: An Old Scourge Returns," a one-day conference held in November in Harrisburg. Addressed were the history, epidemiology, and pathophysiology of TB; current methods of screening and diagnosis; TB and HIV; and protection against TB transmission in the health care setting. Presenters represented the sponsoring organizations—the State Society, the American Lung Association of Pennsylvania, and the Pennsylvania Academy of Family Physicians—as well as the state Department of Health.

Clinical Scholars Program

RWJF is also accepting applications for the 1994 Clinical Scholars Program, "designed to allow young physicians committed to clinical medicine to acquire new skills and training in the non-biological sciences important to medical care systems."

The program offers two years of graduate-level study and research—as part of a university-based, post-residency training program—in priority areas designated by participating institutions. For instance, Johns Hopkins University School of Medicine, Baltimore, Maryland, offers training in organization and financing of health care, and evaluating health care practices and interventions.

For additional information about the Clinical Scholars Program, including a complete list of participating universities, priority areas, and eligibility requirements, call Sheila Libassi at (609) 243-5919. Deadline for applications is March 1, 1994.

PITT GIVEN GRANT TO OPEN REHAB RESEARCH CENTER

The University of Pittsburgh School of Health and Rehabilitation Sciences has received a five-year, $3.5 million grant to open a Rehabilitation Engineering Research Center on Technology to Improve Wheelchair Mobility at the University of Pittsburgh Applied Research Center, Harmarville. The grant was awarded by the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education.

The new center will focus on three main areas of research: 1) improving the reliability and safety of manual and electric wheelchairs; 2) developing computer-assisted design and computer-assisted manufacturing technology for mobility devices, particularly for people with spinal cord injuries; and 3) developing national standards for wheelchair safety and transportation.

Staff at the research center are collaborating with staff at the Harmarville Rehabilitation Institute, Three Rivers Center for Independent Living, and the Rehabilitation Institute in Shadyside. They are also receiving input from a newly formed focus group of more than 30 people involved in mobility issues, to better understand how to improve mobility devices.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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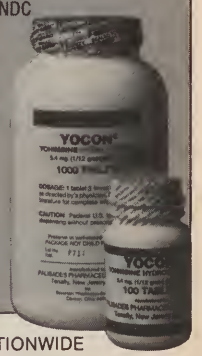

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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OBITUARIES

Harry J. Bremer, MD, *Johnstown*
Hahnemann University School of Medicine, 1943; age 82, died November 16, 1993. Dr. Bremer was a family practitioner.•

George P. Desjardins Sr., MD, *Reading*
Hahnemann University School of Medicine, 1938; age 82, died November 11, 1993. Dr. Desjardins was a pathologist.•

James FitzGerald, MD, *Allentown*
University of Pennsylvania School of Medicine, 1939; age 79, died November 16, 1993. Dr. FitzGerald was an obstetrician/gynecologist.•

David H. Gansman, MD, *Wyncote*
University of Pennsylvania School of Medicine, 1936; age 83, died November 10, 1993. Dr. Gansman specialized in geriatrics.•

A. Paul Knott, MD, *Chevy Chase, MD*
Meharry Medical College School of Medicine, Tennessee, 1926; age 91, died October 10, 1993. Dr. Knott was an internist.•

Henry E. Ober, MD, *Greensburg*
University of Pennsylvania School of Medicine, 1941; age 77, died November 10, 1993. Dr. Ober was a general practitioner.•

Dale M. Posey, MD, *Lititz*
University of Maryland School of Medicne, 1942; age 78, died November 9, 1993. Dr. Posey was an ophthalmogist.•

William D. Todhunter, MD, *Williamsport*
Temple University School of Medicine, 1943; age 75, died October 10, 1993. Dr. Todhunter was a general surgeon.•

H. Ernest Tompkins, MD, *Vero Beach, FL*
Hahnemann University School of Medicine, 1931; age 86, died October 29, 1993. Dr. Tompkins was a radiologist.•

Manrico A. Troncelliti, MD, *Bryn Mawr*
University of Pennsylvania School of Medicine, 1941; age 77, died October 28, 1993. Dr. Troncelliti was a general surgeon.•

Ned Baron, DO, *Philadelphia*
College of Osteopathic Medicine, Iowa; age 60, died September 11, 1993. Dr. Baron was a psychiatrist.

C. Wilmer Brobyn, MD, *Wilkes-Barre*
Hahnemann University School of Medicine, 1944; age 73, died October 26, 1993. Dr. Brobyn was an anesthesiologist.

James A. Ferrante, MD, *Hampton*
University of Pittsburgh School of Medicine, 1963; age 54, died October 24, 1993. Dr. Ferrante was a family practitioner.

Stephen P. Brown, MD, *Somerset*
University of Oklahoma College of Medicine, 1984; age 40. Dr. Brown was an ophthalmologist.

Harry L. Farrell, MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1931; age 87, died September 10, 1993. Dr. Farrell was a general surgeon.

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CORRECTION

In *Obituaries* of the November (page 29) and December (page 52) issues of PENNSYLVANIA MEDICINE, "Thomas Jefferson Medical College" was incorrectly listed as the alma mater for nine physicians. The proper listing for the medical school is "Jefferson Medical College of Thomas Jefferson University."

January

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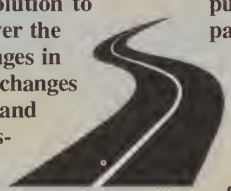

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Dealing with Pain-Related Disabilities: Non-Organic Components of Pain

David W. Florence, MD, MPA
Michael J. Asken, PhD

This article briefly introduces and reviews the "non-organic" components of pain-related disability situations, discusses the effect of the complexity of the problem on physician attitudes and behaviors, provides a description of the non-organic influences and their assessment, and makes suggestions for appropriate goals for intervening in pain-related disability conditions.

The impact of pain-related disability and work-related accidents for this county is staggering. Total costs of $47.1 billion from work-related accidents—with $8.1 billion in medical expenses, 60,000 permanent disabilities and 1.7 million temporary disabilities,[1] 1985 Social Security Insurance disability payments to 2.7 million disabled workers, and 1.2 million dependents at a cost of $1.5 billion per month—suggest the immensity of the problem.[2] However, work-related accidents and pain-related disability are not just a challenge for economic reasons or just for the industrial sector. They also pose a significant clinical challenge and *clinical quandary* for physicians and other health care providers who are asked to intervene in pain-related situations.

Much of the clinical complexity occurs because pain-related disability conditions are truly a biopsychosocial phenomenon. And while that term has recently been used optimistically to define a *comprehensive understanding of health and illness*, in the area of pain-related disability, it has often been seen as representing a clinical curse.

Florence has indicated that physicians are often confused by the relationship of psychological and physical components in pain-related disability, and has observed that, as a result, they may attempt to isolate themselves from the "non-organic" components of pain-related conditions and disability.[3] This stance is likely to become an increasingly untenable position, however, as physicians (especially primary care physicians) acting as gatekeepers to the health care system, will not be able to escape the subjective component in diagnosis, treatment, or determination of impairment and disability.

Basic considerations

As a result of the complexity of information resulting from various examinations of the biological, psychological, and social aspects of pain-related disability, many myths and misconceptions have evolved. Common myths include beliefs of increased depression in females compared to males with chronic pain,[4] ethnic differences in pain manifestations,[5] simplicity and consistency in cross-cultural responses to pain situations,[6] and intensifying hypochondriasis with advancing age.[7]

A second effect of the complexity and related myths is an impact on physician attitudes (predominately negative) toward such patients and conditions. Cunnien has commented on the resultant "plethora" of pejorative terms ranging from "compensation neurosis" to "green poultice syndrome."[8] Research by Barsky, et al. suggests that physicians' use of the term "hypochondriasis" is most closely related to their level of frustration with the patient.[9]

A further effect is that the foregoing may affect accurate perception and diagnosis. In fact, Hendler, et al. have recently reported that the overall rate of inaccurate or incomplete diagnosis in referred chronic pain patients involved in litigation may be as high as 66.7 percent[10] and that "psychogenic" diagnosis may often be present rather than a more appropriate organic diagnosis.[11]

Therefore, variability in information and attitudes are the backdrop against which "non-organic" components must be considered. Physicians, whether or not they feel sufficiently trained in this area, will be increasingly called upon to differ-

At Polyclinic Medical Center, Harrisburg, Dr. Florence is vice president of medical affairs, and Dr. Asken is a rehabilitation psychologist.

entiate or integrate physical and psychological components in pain-related disability situations.

Non-organic factors

Several potential non-organic factors may contribute to the total constellation of the pain-related disability mosaic. These factors—reactive responses, depression, conditioning effects, stress, personality effects, somatoform disorders, and environmental effects—should not be "isolated" from physical conditions. Instead, they should be understood and used as a therapeutic road map in fully understanding the patient, and not pointed to pejoratively or as an indication of invalid complaints. It is crucial to bear in mind Chapman's comments: "The era in which pain was regarded as x percent 'organic' and y percent 'functional' or 'psychological' (where x + y = 100) mercifully appears to be coming to an end."[12]

Reactive responses: Chronic pain from documented lesions can create a variety of reactions and emotional responses in the patient and family. Dworkin, et al. have observed that persistent pain translates into suffering and may be manifest in demoralization, affective disturbances, preoccupation with pain, limitations of personal, social, and work activities, frequent medication and health services use, and adoption of the sick role.[13]

Traumatic injuries may produce specific responses, ranging from fear of reinjury upon returning to work to post-traumatic symptoms, if not a true post-traumatic stress disorder.[14] The quality of the relationship between employer and employee may mitigate or fuel feelings of fear, blame, anger, or concern about retaliation for actions occurring by one party or another during the period of pain-related disability.

Depression: The relationship of pain and depression is clear, if complex. Persons with chronic pain-related conditions are depressed, depressed persons complain frequently of pain,[15] the number of pain sites is predictive of depression,[16,17] and depressed chronic pain patients have more negative thoughts than either non-depressed chronic pain patients or controls.[18] Also, depression may occur as a reactive response to pain-related disability, or it may proceed its onset and risk exacerbation.[19] In either instance, its assessment and treatment are essential, especially given that there is a small but meaningful relationship between depression and rehabilitation outcome.[20]

Conditioning effects: Behavioral psychologists have for some time reported the role of conditioning effects as factors in chronic pain and disability situations. Classical or Pavlovian conditioning has an influence through generalization of pain and distress to multiple situations, or through stimulus effects such as pill bottles on the nightstand.[21] Operant or Skinnerian conditioning can maintain pain behavior by environmental contingencies of sympathy/attention, relief from responsibility, or economic advantages. Such factors have been reported to affect activity levels, medication intake, and reports of pain.[22]

Cognitive behavior in the form of cognitive distortions and negative expectations are typically part of chronic conditions.[23] Such distortions have been associated with the degree of disability reported by chronic pain patients,[24] and reinterpreting negative conditions has yielded significant changes in improved ratings of quantity and intensity of pain.[25]

Stress: Though at times not a precise clinical or scientific term in its use, stress, in the form of anxiety or psychophysiologic responses, can result in musculoskeletal effects and discomforts as discussed by Florence.[26] The common perception of a cycle of pain and tension in chronic conditions[27] suggests the need for its interruption for effective intervention.[28] Biofeedback, muscle relaxation techniques, and other approaches provide a means to address such issues.

Personality effects: Interest in the role of personality characteristics in the area of chronic pain and disability has a long history. It is the authors' opinion that data from much of this work is varied, difficult to access and assess, and of more theoretical than clinical utility.

Some recent work in the area of coping types, such as the "hardy personality,"[29] may be helpful in understanding how persons deal with chronic pain, disability, and other major life stressors. The more traditional approach of trying to delineate certain personality types that are prone to develop certain types of illness has little empirical support; most related personality changes are now generally seen as the *result* of a chronic condition, rather than an etiologic factor in it.[30]

On the other hand, individuals with personality disorders do become injured, and their style can interact with their physical condition and other issues related to the chronic pain or disability situation. Therefore, familiarity with the American Psychiatric Association's "Di-→

"Much of the clinical complexity occurs because pain-related disability conditions are truly a biopsychosocial phenomenon."

agnostic and Statistical Manual, Third Edition Revised" (DSM-III-R), which provides descriptions and definitions of personality disorders, is important. The presence of an anti-social personality disorder, obsessive-compulsive personality disorder, or passive-aggressive personality disorder, to name just a few, can considerably complicate a pain-related disability situation and must be understood and addressed.

Somatoform disorders: The particular class of psychiatric diagnosis known as somatoform disorders is responsible for much of the confusion and frustration that often surround the chronic pain and disability experience. Somatoform disorders are defined by the presence of physical symptoms suggesting physical disorder for which there are no demonstrable organic findings or no known physiologic mechanisms. Additionally, there must be positive evidence that the symptoms are linked to psychological factors. Conversion disorder, hypochondriasis, and somatoform pain disorder represent this category and can also be found well-defined and described in the DSM-III-R.

While these disorders can be found in a population of disabled workers,[31] they must be used only where diagnostically accurate and not indiscriminately or by default. Somatization disorders can also present with co-morbid problems of depression and anxiety.[32]

Somatoform disorders must be differentiated from malingering or factitious disorders, where there is a conscious and deliberate intent to deceive for purposes of personal gain. While somatoform disorders create confusion for clinicians, it is malingering that fuels suspicion, anger, and negative attitudes that frequently exist toward these patients and situations. Rogers has provided indications of malingering and formalized them in *The Structured Interview of Reported Symptoms* in an effort to decrease subjective and variable approaches among clinicians toward this difficult problem.[33]

Several authors have raised cautions about the misuse of these diagnoses, one of which is differentiating malingering/somatoform disorders from defensiveness. Pain-related disability patients may have valid reasons for being guarded, doubtful, or even suspicious of evaluations and treatment motives. Also emphasized is that the use of such a diagnosis does not "dispose" of the case, but calls for further appropriate interventions.[34,35,36]

"Beale has emphatically argued that worker compensation laws influence the course of disease, access to care, diagnostic evaluation, treatment, response to treatment, and residual disability."

Environmental effects: The concept of environmental effects has also been used on pain and disability conditions in a broader, but related sense, to that of behavioral psychologists. Typical environments which influence "risk factors" for chronic dysfunction include family of origin, current family, the workplace, insurance and social welfare systems, and the health care system.[37,38]

For example, Gentry has noted the influence of family origin experiences as models for coping with pain and disability,[39] and Goodenow, et al. have reported the importance of social support as a major predictor of functioning in women with rheumatoid arthritis.[40]

Well-intentioned, but excessive or repetitive attention to complaints or the use of expensive diagnostics and workups by health care providers have been reported as factors in maintaining problematic conditions, as well,[41] and Florence has written that patients on multiple compensatory systems rarely respond to any type of treatment or rehabilitation, especially if compensation exceeds that obtained from working.[42] Beale has emphatically argued that worker compensation laws influence the course of disease, access to care, diagnostic evaluation, treatment, response to treatment, and residual disability.[43] To complicate matters once again, however, other work, such as that of Pelz and Merskey, failed to find significant differences in the behavioral patterns of compensation versus no compensation cases.[44]

Assessment of non-organic factors

The accurate assessment of non-organic factors in pain-related disability remains an urgent challenge to the field and a frustration for clinicians. While a description of all proffered approaches with their strengths and weaknesses is beyond the scope of this paper, some general guidelines can be offered.

Assessment of pain-related disability must begin with a comprehensive medical examination. Past diagnostics must be reviewed and utilized, but not repeated where unnecessary, nor should they be the basis for "snap decisions" about "career" disability patients.

Especially where there are inconsistencies between findings and function, but also in all pain-related disability situations, attention must be given to the potential contributions of non-organic factors. An interdisciplinary approach with emphasis on a comprehensive psy-

chological evaluation has been suggested as most effective.[45] A variety of psychological tests are available and can be used if carefully selected and used by professionals familiar with the idiosyncrasies of these tests in this type of specialized situation. Dworkin, et al. have suggested that more important than which test is used is how it is used. They especially support the need for repeated measures or observations,[46] in the same manner that no physician would rely on a single blood pressure reading to diagnose and treat hypertension.

Managing the disability

It is clear that pain-related disability has earned the appellation of the disease of the "Ds": dysfunction, disuse, dramatized complaints, depression and demoralization, disability, and drug misuse. Nonetheless, it remains an area in urgent need of continuing and rational attention.

There are certain conclusions that can be drawn from the current state of knowledge about pain-related disability that may be helpful in managing such difficult problems:

- Pain-related disability has a profound impact on the patient, family, and health care provider at many levels.
- Pain-related disability is truly a biopsychosocial phenomenon.
- Pain-related disability requires a comprehensive medical work-up, logically derived and not unnecessarily repetitive.
- Pain-related disability evaluations must be free of negative emotional responses which such conditions often elicit in health care providers.
- Pain-related disability additionally requires that evaluative judgments be based on empirically derived knowledge, not "hearsay" or emotionally driven and selective perceptions of clinical experience.
- Pain-related disability requires consideration of non-organic influences.
- Pain-related disability requires experienced use and valid applications of non-organic assessment measures.
- Pain-related disability may well require an interdisciplinary approach for adequate intervention.
- Pain-related disability requires that suspicion of malingering or factitious disorders be addressed and not simply identified or disdained.
- Pain-related disability requires setting reasonable goals.

In closing, a few observations about the nature of reasonable goals in pain-related disability situations seem essential.

There is a consensus that establishment of a pain-free state may not be achievable in many situations. Dworkin, et al. have suggested that the goal of effective treatment is to limit the dysfunctional impact of pain and change behavior without necessarily controlling pain per se,[47] and Florence has noted a critical goal is to reduce the perception of disability and describes returning to the work site or other appropriate function, with or without pain relief, as a desirable outcome.[48] Other reasonable goals are a reduction of the fear of injury, a reduction of the fear of pain, and a reduction of the fear of returning to work or function.[49]

There is strong agreement with the observation that the appropriate role for the physician is the search for social and psychological factors enhancing the patient's disability and, ultimately, guiding the patient in a recovery process, addressing both physical and psychological needs.[50]

References available upon request.

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NEWSMAKERS

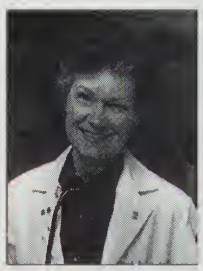
Paul J. Fink, MD, was appointed associate vice president, Albert Einstein Healthcare Network, Philadelphia.

D. Holmes Morton, MD, Strasburg, received the 1993 Albert Schweitzer Prize for Humanitarianism. Dr. Morton treats genetic diseases that cripple and kill children.

John C. Wallendjack, MD, Harrisburg, was named director of HealthAmerica of Central Pennsylvania, which has agreed to join with Berkshire Health Plan (BHP) to offer its health maintenance organization in the Reading/Berks County area.

Bartley P. Griffith, MD, chief of cardiothoracic surgery and professor of surgery, University of Pittsburgh Medical Center, was named to the Surgery, Anesthesiology, and Trauma Study Section, Division of Research Grants, National Institutes of Health.

Sarah S. Long, MD, professor of pediatrics and associate professor of microbiology and immunology, Temple University School of Medicine, Philadelphia, has received Temple's Great Teacher Award for 1993.



Dr. Long

F. William Sunderman, MD, PhD, director of the Institute for Clinical Science, Pennsylvania Hospital, Philadelphia, directed "Advances in the Laboratory Diagnosis of Cancer and Their Clinical Applications for the Association of Clinical Scientists," a four-day seminar held late last year at the Medical College of Ohio. He also spoke at the combined meetings of the XV International Congress of Clinical Chemistry, the 6th Asian-Pacific Regional Congress of Clinical Biochemistry, and the 31st Annual Conference of the Australian Association of Clinical Biochemists on "Evolvement of Clinical Chemistry in the United States."

Sarah Winkelmeyer Holt, DO, Lancaster, recently delivered a baby at Community Hospital of Lancaster—nothing unusual about that. She's delivered hundred of babies during her seven years in family practice; however, during this delivery, she was in the first stages of labor herself. About 27 hours later she had her own baby. The following morning, she was on rounds again, checking on her last patient.

Marluce Bibbo, MD, director of cytopathology, Thomas Jefferson University, Philadelphia, was named the first Warren R. Lang professor of pathology and cell biology at the university.

Dr. Bibbo

Richard Tipperman, MD, an ophthalmologist at Wills Eye Hospital, Philadelphia, was featured on "Tell It Like It Is," an hour-long call-in show on WJIC News Talk Radio, Philadelphia.

Joan Keit, MD, chief resident, Department of Radiation Oncology and Nuclear Medicine, Hahnemann University, Philadelphia, received the 1993 Distinguished Resident Award from the American Association for Women Radiologists.

Penn State's College of Medicine, Hershey, has named **John A. Waldhausen, MD,** as associate dean and director, University Physicians Center, and **James M. Herman, MD,** as assistant dean for primary care, Hershey Medical Center. Also at the college, **William S. Pierce, MD,** Evan Pugh Professor of Surgery, and chief, Division of Cardiothoracic Surgery, was elected to the Institute of Medicine of the National Academy of Sciences.

North Penn Hospital, Lansdale, has announced the following medical staff promotions: **Steven Sklar, DO,** chairman, Department of Family Practice; **Randy Grinspan, DO,** chairman, Department of Emergency Medicine; and **Felix Scherzinger, MD,** chairman, Department of Pediatrics.

Ronald B. Herberman, MD, director, Pittsburgh Cancer Institute, Pittsburgh, and professor of medicine and pathology, University of Pittsburgh School of Medicine, was named the first Hillman Professor of Oncology at the university.

Henry Rosenberg, MD, professor and chair, Department of Anesthesiology, and **John Shutack, MD,** associate professor of anesthesiology, Hahnemann University, Philadelphia, were honored for their work with the telephone hotline of the Malignant Hyperthermia Association of the United States.

Husband and wife **Harold Isard, MD,** and **Sonia Stupniker, MD,** Melrose Park, received the Physician Leadership Award from the Albert Einstein Society, Philadelphia, for their philanthropic service to the Albert Einstein Healthcare Network and their community.

Robert Fry, MD, has been appointed the first Gerald J. Marks professor of colorectal surgery at Jefferson Medical College and Thomas Jefferson University Hospital, Philadelphia.

Jonathan M. Raines, MD, attending psychiatrist at the Institute of Pennsylvania Hospital, Philadelphia, was elected secretary of the Philadelphia Psychiatric Society.

Arthur M. Gershkoff, MD, Philadelphia, was appointed clinical director of stroke rehabilitation at MossRehab Hospital, Philadelphia.

Richard A. Sullivan, MD, medical director, Chestnut Hill Rehabilitation Hospital, Wyndmoor, received the Pennsylvania Association of Rehabilitation Facilities' Distinguished Service Career Award. The award is given yearly to an individual retiring from a distinguished career in the field of medical rehabilitation.

Dr. Sullivan

St. Agnes Medical Center, Philadelphia, has named **Perry Weiner, DO**, as director of urology.

J. Thomas Danzi, MD, was named medical director and associate dean for clinical affairs, Hahnemann University, Philadelphia.

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4:00-5:00	Case Presentation	*Bennett D. Schalet, D.O.*
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The New Tax Law: Here's What It Means for Your Practice

The Health Care Group

Last month in this column, we discussed how the new federal tax law—the 1993 Revenue Reconciliation Act—will impact individual physicians. Among the provisions discussed were: higher tax rates, limits on itemized deductions, personal exemptions, charitable contributions, estimated payment safe harbors, and others. This month we look at how the business provisions of the new law will impact physicians' practices.

Social Security taxes

In addition to increasing income taxes, the new federal tax law increases the amount of Social Security or self-employment taxes that physicians and other high income earners will pay. Beginning this month, the $135,000 cap on the hospital insurance portion of Social Security tax is repealed. Physicians will pay a combined 2.9 percent hospital insurance tax on every dollar of compensation.

Higher corporation income taxes

Retroactive to January 1, 1993, the flat tax rate on the net income of personal service corporations is increased from 34 percent to 35 percent. See the comparison of corporate and personal rates (next page) for an idea of what this means.

Business expenses of depreciable assets increased

The new law increases the maximum amount that can be expensed for equipment or other tangible asset purchases used in a trade or business under IRS Code Section 179 from $10,000 to $17,500, effective for all purchases on or after January 1, 1993. As a result, practices, whether incorporated or not, can now deduct up to $17,500 in a tax year for purchases of tangible personal (as opposed to real estate) property used more than 50 percent in the practice.

Intangible assets resembling goodwill deductible

Acquired goodwill and other intangible assets can be amortized (e.g., "written off" pro-rata) over 15 years; previously, amortization on these items was impermissible. This change is effective for property acquired after August 5, 1993. Taxpayers are given an option to use 15-year amortization for goodwill and intangibles acquired prior to August 15, 1993, but after July 25, 1991.

The following intangibles are eligible for this write-off: goodwill, going-concern value, workforce in place, information bases, know-how, customer-based intangibles, supplier-based intangibles, licenses, permits, and covenants not to compete.

Off-the-shelf computer software is not eligible for 15-year amortization; neither is other software unless acquired as part of business asset purchase. The exclusion of computer software is not necessarily bad since depreciable software is generally depreciable over three years under existing law. Software bought with computer hardware is generally depreciable along with the hardware.

This provision is intended to curb the games customarily played between parties to a business sale or other major purchase transaction. Buyers, under prior law, sometimes tried to negotiate purchase allocations toward deductible items as opposed to items which could not be written off at all (e.g., goodwill) or which could not be written off without the difficult task of proving that a definite useful life existed (e.g., patient charts and records).

Health insurance deduction for the self-employed

The new law restores, temporarily, the deductibility for 25 percent of the health insurance premiums paid by a partner or shareholder in an "S" corporation. The change is retroactive to July 1, 1992. However, the restoration of this deduction will again expire beginning with the 1994 tax year.

The temporary restoration creates a refund opportunity for physicians whose practices are partnerships or "S" corporations on their 1992 individual tax returns. By filing an amended return, a physician can deduct 25 percent of the insurance premiums actually paid from July 1, 1992, through December 31, 1992, for coverage for the physician, his or her spouse, and dependents.

The deduction will have the double effect of reducing adjusted gross income and increasing the allowable itemized deductions for taxpayers whose adjusted gross incomes are over $120,525 after the deduction (because the phase down of itemized deductions decreases correspondingly to the decrease in adjusted gross income). This should increase the refund.

Since the expiration occurs *after* 1993, the full 25 percent deduction is permissible on the 1993 return. Unfortunately, the retroactivity of the tax rate changes significantly reduces tax planning strategies. Nonetheless, the following planning techniques, some rather traditional, may effectively minimize the impact of the law.

Maximize 1993 compensation: Generally, it is best to defer income, whether short-term (such as until the following taxable year) or long-term (such as until retirement). However, since the $135,000 limit on the hospital insurance tax remains intact for 1993, a physician expecting to earn at least that much compensation in 1993 might consider accelerating 1994 compensation into 1993. Acceleration of $50,000, for example, would save $1,450 in hospital insurance tax.

For example, in 1993 a practice could borrow enough money from a bank to advance to its doctor three months' compensation. The practice would then repay the loan during the first three months of 1994 in lieu of

paying a salary to the doctor. In this event, however, the doctor must compare the savings of tax versus the cost of borrowing (i.e., interest).

Maximize current deductions: As always, current year deductions should be maximized to minimize current taxable income. Prepaying real estate taxes, mortgage payments, and estimated state income taxes in December rather than in the next year are the usual techniques.

Maximize retirement contributions: As a further means to reduce taxable income, maximize contributions to tax-deferred qualified retirement plans such as 401(k) plans, Keogh plans, IRAs, and profit-sharing and pension plans. Income derived from investment into these plans is not taxed until withdrawn. The investor is not generally required to take distributions from a qualified retirement plan until April 1 following the calendar year in which he or she reaches age 70½.

For hospital-employed physicians, non-qualified deferred compensation arrangements are available which may be used as a substitute for, or a supplement to, a qualified plan. Tax-deferred annuities are another option for long-term investment deferral. Non-qualified arrangements, however, are generally unsecured, meaning that any funding is usually subject to the hospital's general creditors.

Consider tax-exempt investments: Physicians should consider restructuring the fixed-income or bond portion of their investment portfolios to include some or more tax-exempt municipal bonds. As a result of the rise in tax rates, the effective (after-tax) rate of return of a taxable investment is likely to be lower than for tax-exempt investments. To reduce bond value volatility, avoid maturities of longer than three to seven years.

Further, consider increasing investment in growth stocks in lieu of income stocks (stocks that historically pay dividends) to maximize deferral and to take advantage of the capital gains/ordinary income tax rate differentials. Remember, the first priority in structuring a balanced investment portfolio is to meet personal overall financial needs and risk tolerance. Avoid making investment decisions solely for tax reasons.

Compare individual and corporate rates: Physicians in incorporated practices should compare the new corporate tax rate (35 percent) to the marginal individual tax rates on private income before making a larger non-deductible purchase for the practice. In recent years, owners of professional "C" corporations were sometimes advised to finance practice purchases with borrowed funds rather than using corporate income for this purpose—hence, paying taxes at lower individual rates than higher corporate rates.

However, under the law the two new marginal rates on individual income (36 percent and 39.6 percent) are higher than the tax rate on professional corporation income. In addition, the increased expensing deduction for certain capital purchases may make it more attractive to purchase with corporate funds. Therefore, physicians may need to reconsider practice purchase philosophies. When comparing rates, however, remember to factor in the state rates.

The contributing author, Mark A. Abruzzo, JD, is an attorney with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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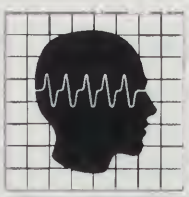

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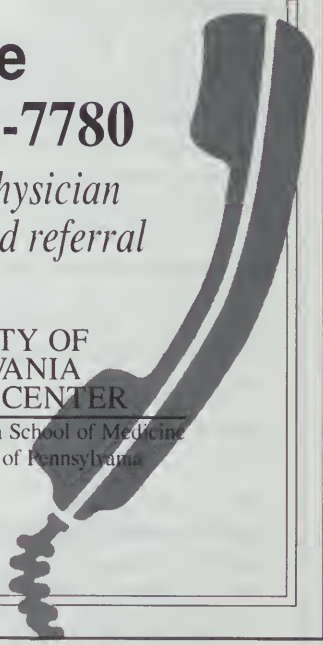

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Politics: A Game Doctors Won't Play

Andre C. Blanzaco, MD

Excerpted with permission from *Philadelphia Medicine*, Volume 88, Number 7, July 1992.

Lawyers, when they start into private practice or join an established law firm, are well aware that changes in laws or governmental regulations will have a strong impact on their salaries. They keep abreast of impending legislation, make certain that their position is well lobbied to the legislators, and, importantly, donate generously to their political action committee (PAC) to keep in touch with key legislators. This is a way of life for members of the bar, especially the plaintiff bar. It ensures them of being at the "grassroots" of law-making, where it makes the most impact on their wallets.

In the past few years, events have started to make an impression on the purse-strings of physicians: malpractice laws, the escalating prices attached to insurance premiums and/or CAT fund assessments, auto insurance reform, the Medicare Fee Control Act, office laboratory regulation, Title X "Gag Rule" legislation, workers' compensation reform, RBRVS, etc., etc. Then along comes health system reform. Physicians cannot help but be confused and overwhelmed by this barrage of laws and regulations. We have never been so besieged, let alone in such a short framework of time.

Add to this the general apathy of physicians when it comes to things alien to their own practice of medicine; add the fact that only 47 percent of physicians belong to organized medicine through their county and state societies, and the AMA; that only 17 to 20 percent of physicians contribute to medicine's PAC; and that only 40 percent of physicians are registered to vote, let alone appear at the voting booth on primary and regular election days.

Most physicians do not know the name of their senators, congressmen, state representatives, local commissioners, school board members, and judges. Physicians, in general, have a very difficult time regulating things in their own practice, their hospitals, their own medical societies, and in their own specialties. Regulation and discipline are left to "the other guys."

Well, doctors, it is now time to wake up and get involved. Legislators, and some of our physician leaders, have been telling us, "Make your own rules and regulations, and police them diligently, or someone else will do it for you."

What can you do as a physician, right now, to reverse the roles that we have gotten ourselves into, so that we can finally deal from a position of strength?

First, those of us who are members of organized medicine should make every effort to convince the non-member physicians on our hospitals staffs to join through our county societies.

Second, we members should become involved in some facet of Society affairs. Just paying the dues and saying one is a member is not enough. If every member would give five minutes of his or her time, every month, to some aspect of organized medicine, what an organization we would have!

Third, know your Hospital Medical Staff Section representative—better yet, become a member of HMSS—and participate in their excellent programs.

Fourth, contact the State Society if you have any personal or "grassroots" contact with local legislators. Our Legislative Action Teams (LATs), on both state and federal levels, maintain close personal contact with legislators in order to have easy access to their ear when a particular legislative item is important to the Society. There is great need for physicians to serve on their local LATs.

Legislators are often not in tune with medical information. It is the job of the physicians—working with the State Society's governmental and regulatory staffs—to see that they are provided correct information.

Finally, you need to become involved in our PAC. Unfortunately, less than 20 percent of the membership contribute to this cause. A category with the annual dues billing requests contributions, which must be sent by separate check. The usual contribution is $100, and a Keystone Club contribution is $250.

It is up to us to want to learn the game, master the rules, and turn that knowledge into brilliant strategy to come out a winner, almost every time. It's up to you to do something about it.

Dr. Blanzaco, an obstetrician/gynecologist in Philadelphia, is past chairman of the Society's Council on Governmental Relations and an at-large-member of the Pennsylvania Medical Political Action Committee board.

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However, it seems that non-physician health care providers are flocking to Harrisburg and Washington for qualification — by legislation rather than education – to hang a shingle and practice medicine.

Though everyone, including the Pennsylvania Medical Society, strongly supports responsible reforms to improve access and lower costs in our current health care delivery system, lowering licensing standards and broadening the scopes of practice for health care providers who did not attend medical school is not the answer.

From the right to prescribe medicine to the right to perform surgery, the requirements needed to graduate from medical school and become a licensed physician are often taken for granted in the fundamental relationship between physicians and their patients.

Skyrocketing malpractice liability insurance costs, which the Clinton Administration's reform proposal has ignored, will soar even higher if the standards for practicing medicine are lowered.

It's ultimately the responsibility of Pennsylvania physicians to protect their patients from those who are seeking to use the reform movement as a decoy to lower medical licensing standards in an effort to practice medicine without attending medical school and a medical residency.

Please don't duck your responsibility to protect the high standards of medical care in Pennsylvania and across America. Join and/or upgrade your membership in PAMPAC today.

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Health System Reform Focuses on the Primary Care Physician
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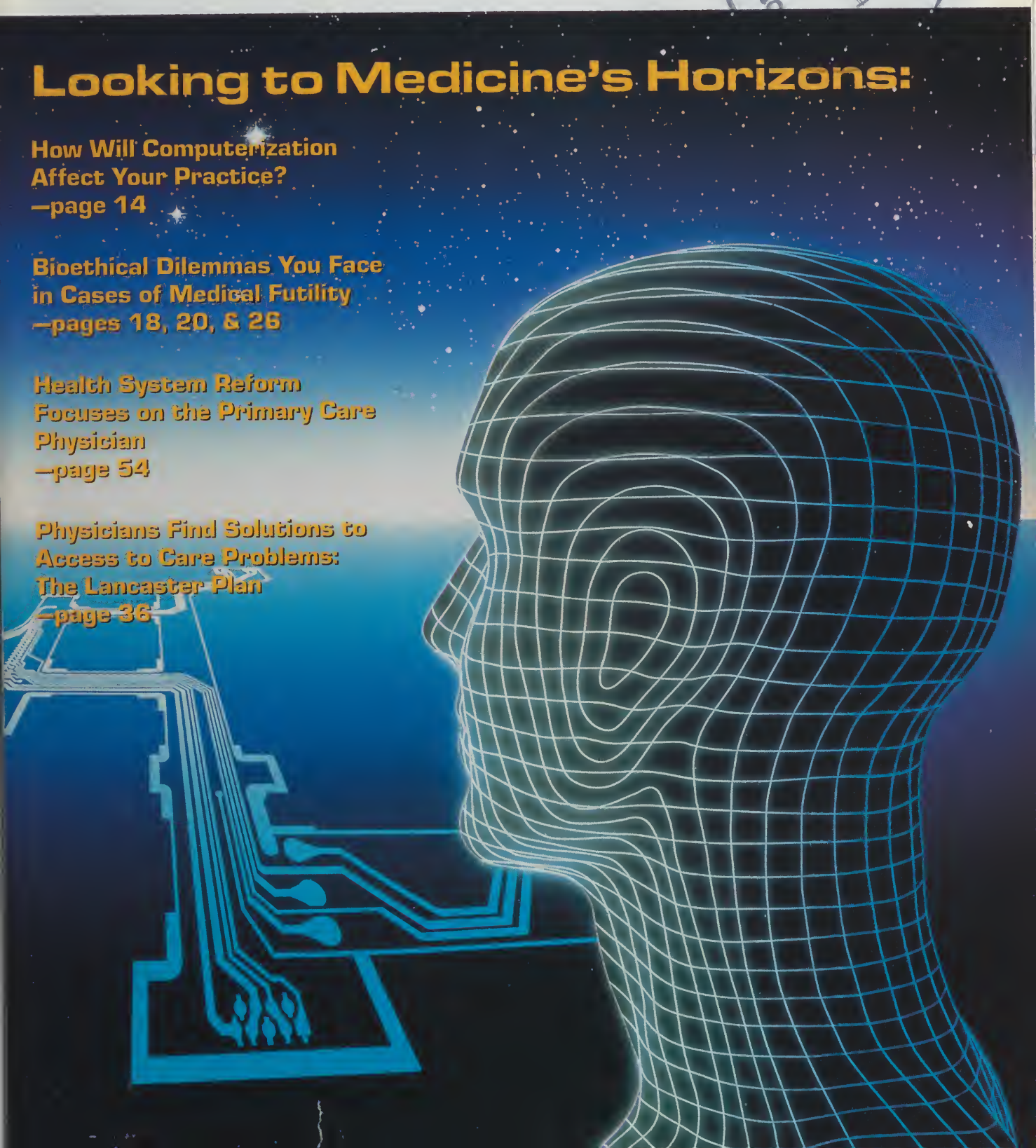

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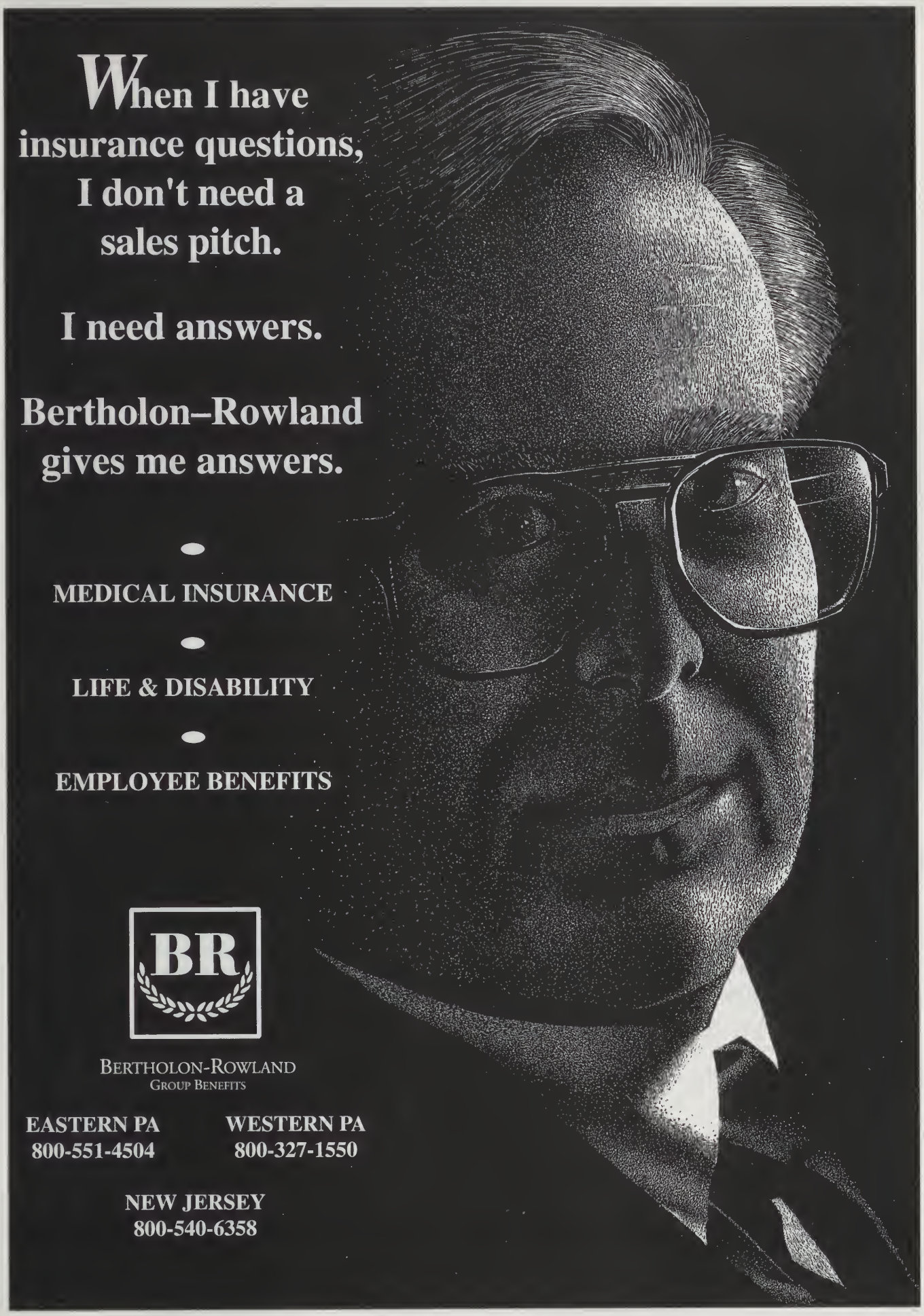
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With the future of medicine and health care "reforms" looming, physicians who plan to automate their practices—or upgrade an existing system—will want to start now. This article offers a series of questions to help physicians define their needs and develop an accurate blueprint of their plans.

Cover photo by Uniphoto, New York

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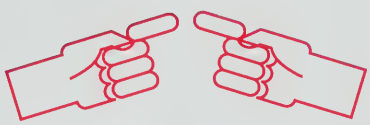
As technology has expanded our ability to prolong physical existence, the futility of continuing medical treatment in certain cases has come under increasing debate. Medical ethicists present both sides of the argument:



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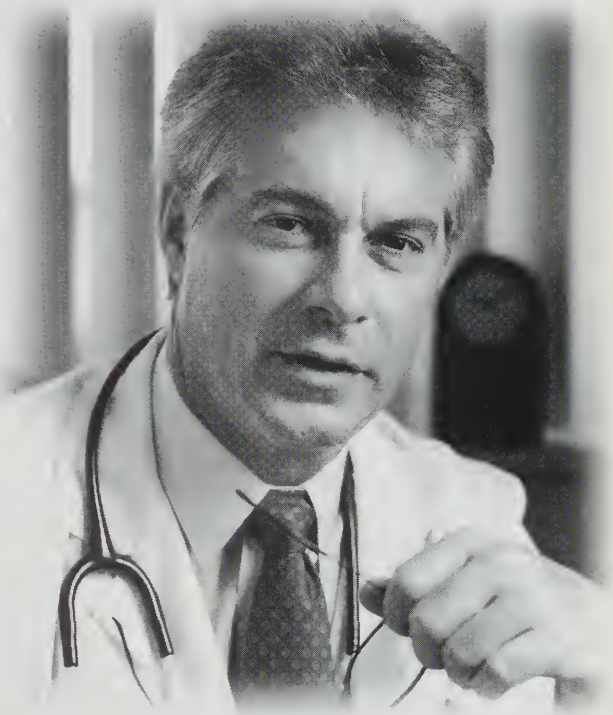
he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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MEDIGRAM

AMA LAUNCHES ANTITRUST CAMPAIGN: The AMA launched a massive grassroots campaign in late January to enact the Health Care Antitrust Improvements Act of 1993 as part of any health system reform legislation passed this year. The act was introduced as S. 1658 and H.R. 3486.

Stating that enhanced physician involvement in the changing medical delivery system is vitally important, the AMA said: 1) any reform package adopted this year must mandate a broad physician role in all health plans and in federal health care policy; 2) current legal impediments to physicians acting together to influence health care delivery must be removed for the benefit of all patients; and 3) while these bills would represent a major first step toward achieving significant antitrust relief, they should be viewed as "placeholder" legislation for organized medicine, and more is needed in antitrust relief and other physician involvement matters.

The AMA believes antitrust reform must give physicians the right to: negotiate with insurance and hospital plans about the terms of the plan; organize physician-controlled networks without fear of antitrust violation; participate in a negotiated rulemaking process with federal and state governments regarding any new rule or regulation involving medical practice prior to its implementation to eliminate government over-regulation and the hassle factor; form committees with health care plans with legal rights to influence medical and other plan policies; and be involved in establishing standards of quality, treatment, competence, and data collections regarding physicians and health care delivery systems.

THE STATE SOCIETY, IN COOPERATION WITH THE AMA, IS ENCOURAGING PHYSICIANS TO CONTACT THEIR U.S. SENATORS AND REPRESENTATIVES TO URGE THEIR COSPONSORSHIP OF H.R. 3486 AND S. 1658. By securing cosponsors of these bills, the AMA believes medicine will be in a stronger position to begin to advocate broader relief as Congress addresses reform in its committees. Copies of communications should be sent to the Society's Division of Governmental Affairs.

NEWEST CABG REPORTS RELEASED THIS MONTH: The Pennsylvania Health Care Cost Containment Council (PHC4) on February 3 released its newest Consumer and Technical reports on physician-specific coronary artery bypass graft (CABG) surgery. The Society still has some concerns about the reports, which are based on 1991 data, but says they are an improvement over reports published in 1992. Added to the reports this year are 1990/91 data comparisons, clearer explanations of mortality statistics, and technical improvements. For free copies of the reports, write to PHC4, Suite 400, 225 Market Street, Harrisburg, PA 17101.

IMMUNIZATION ADMINISTRATION FEE BILLABLE TO BLUE SHIELD: Physicians are reminded that Pennsylvania Blue Shield will reimburse for an administration fee in addition to the immunizing agent when providing an immunization service. Procedure code W0353, (Intramuscular or subcutaneous injection of immunization agent) should be billed in addition to the drug code on a separate claim line. If you have not billed for the administration code, retroactive reimbursement is available up to one year from the date the service was rendered. Direct any questions regarding how to bill for this service to the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

ALLIANCE DONATES $1,000 TO AID EARTHQUAKE VICTIMS: The Pennsylvania Medical Society Alliance has donated $1,000 to aid victims of January's Los Angeles earthquake. The money was distributed in consultation with the California Medical Association Alliance. To make a donation, send a check payable to: The Educational and Scientific Trust, Pennsylvania Medical Society, Alliance Emergency Assistance Fund.

IMGs INVITED TO MARCH FORUM: Representatives of the Society's Advisory Committee on International Medical Graduates (IMGs) are invited to attend the AMA's Fifth Annual IMG Forum, to be held March 16-18 in Washington, DC. The forum will include congressional visits and feature a special training session on speaking techniques. For more information, call the AMA IMG Services Unit at (312) 464-5624.

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New Spring Assembly Welcomes All Members

John W. Mills, MD
Medical Editor

Coming in April is the Pennsylvania Medical Society's "Spring Assembly," which you have known as Leadership Conference for a number of years. Our theme this year is "Forging Alliances...Assuring Your Future." It will run from noon on April 19, 1994, through noon, April 20, at the Harrisburg Hilton and Towers.

The name change was prompted by the impression among some groups within the Society that the conference was "only for leaders" or those who aspired to be leaders. Nothing could be further from the truth.

Years ago, this meeting originated as the officers' and trustees' conference, which did signify a strong leadership attendance. When the name was broadened to "Leadership Conference," and top-notch plenary speakers and useful workshops were added, attendance swelled. However, this year's committee felt that many members were still intimidated by the name, especially younger members and minorities—thus the name change.

Your committee has worked diligently each year to better the conference over the previous one. In general, I think we've been successful. Recently, we instituted an annual brain-storming session of the committee, within a couple of months post conference, in which we analyze attendance and comments in an effort to become visionary in our projections and planning. This has proved to be very helpful and rewarding.

The committee is appointed by the Society's board each year following the conference. Members may serve five years, and this year we are particularly fortunate to have a female, non-board member on our committee.

At our brain-storming session in July last year, we really pulled out all the stops and considered a myriad of changes. One was the name—we hope you approve, but more importantly, we hope you come.

Another change will take place in 1996. We have scheduled a weekend Spring Assembly to allow more families to attend, and have reserved the newly refurbished Lancaster Host for the meeting.

We are trying to appeal to more members on a broader scale and hope the weekend format will be inviting. I must say that mentioning child care and spousal activities, etc., raised some eyebrows, but we think it will be a "GO" Spring Assembly in '96, and add a new dimension and new look to a supposedly "male-dominated" meeting. Gentlemen (generic), we need to be aware of the "glass ceiling" and help to eliminate it in the Pennsylvania Medical Society—this can only increase our stature.

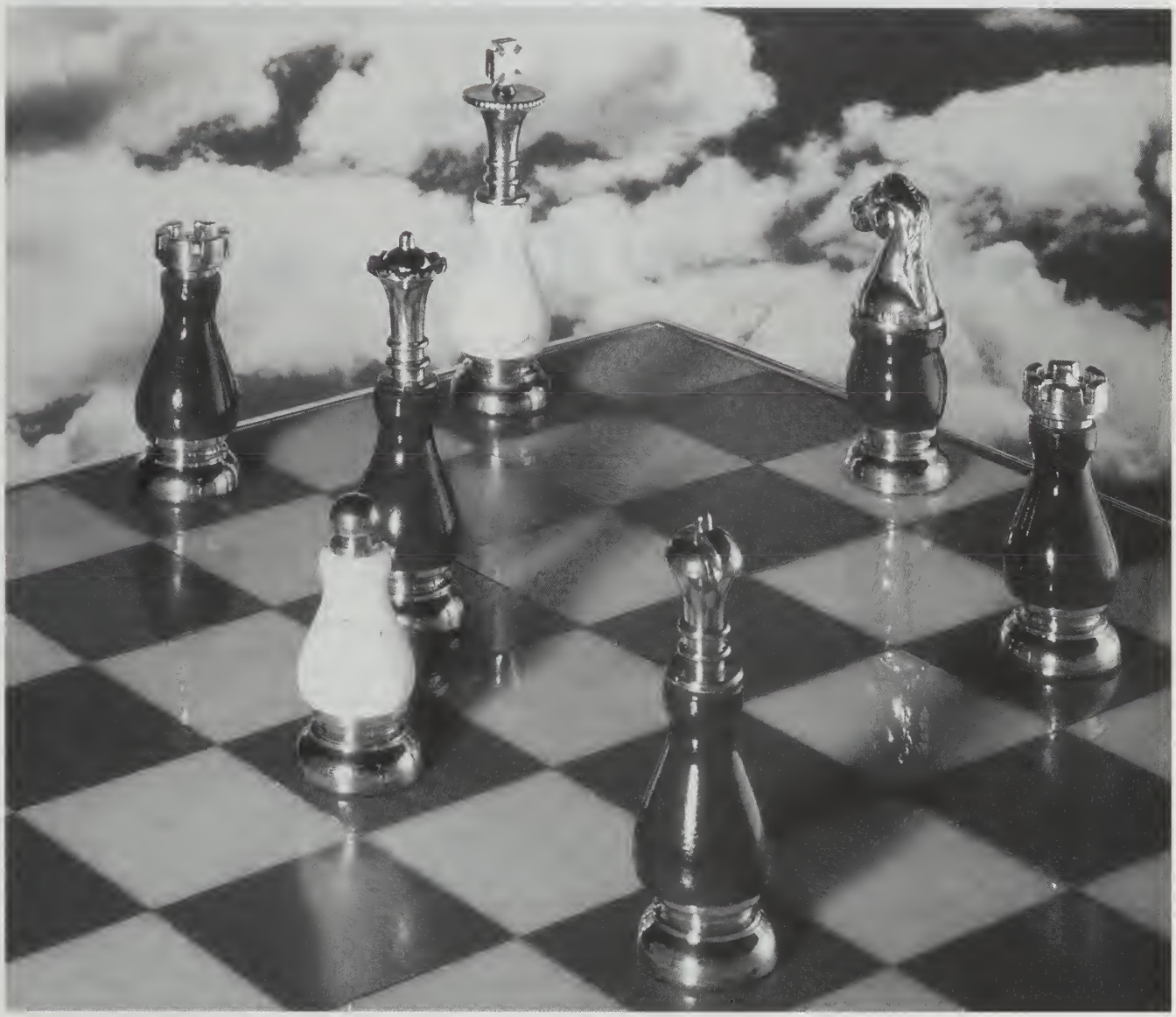
To get back to this year's Spring Assembly, details are outlined on pages 42 and 45 of this issue, but let me emphasize that it includes four super plenary speakers, and break sessions with each, so you can question them on a one-to-one basis and gain valuable information for your strategy in dealing with health system reform. On Wednesday morning, we will offer practical, practice-enhancing workshops.

Another innovation added in 1993 was the promotion of on-site vendors. This was done for two reasons: 1) to help defray expenses (they keep going up like everything else—especially speaker fees); and 2) to expose you to new products of all types—medical, business adjuncts, etc. Despite some negative comments over the vendors, the committee felt that we needed to move forward in this potential area of revenue.

Last month, I was very critical of the AMA's Physician Forum, "Agenda for Action," held in November in Philadelphia. (You should have seen my original manuscript!) It was felt that by being negative about the AMA meeting, I would scare members away from our Spring Assembly. No way. Our members have supported the Leadership Conference (old name), and they know they'll get their money's worth with practical information they can use. There can be no comparison between the AMA's Philadelphia meeting and our Spring Assembly.

The stakes are huge in the health system reform debate. I encourage you to attend the Spring Assembly to get practical advice and knowledge about how to deal with the changing times in our profession. We promise a fast-moving meeting, short on rhetoric and long on help.

Dr. Mills is chairman of the Society's Spring Assembly Committee.



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What Not to Hope For: Practicing Under Government Rule

Martin A. Murcek, MD

I had the pleasure recently of speaking with Dr. Miroslav Zeleznik, who came to the United States 23 years ago from Bratislava, Czechoslovakia, where he had practiced medicine under the communist regime since 1958. I thought Dr. Zeleznik could provide me with some insight on the realities of a government-run health system from the physician's perspective. His observations follow.

Becoming a doctor under the socialist regime meant meeting certain requirements, in addition to the academic ones you would expect. If you didn't come from a "good proletarian background," you didn't go to medical school.

Once graduated, Dr. Zeleznik became what we call a family practitioner associated with a hospital. The other major areas of practice were "industrial medicine" and "adolescent medicine." Doctors were either associated with a hospital, or less frequently, worked out of a state-provided office.

Where you practiced was decided by the state. "If they liked you," Dr. Zeleznik said, you could get a desirable assignment. "If you had a good friend, you can get to heaven, too," he also observed.

The organizational structure within the hospital was straightforward: Physicians worked in teams, under the direction of a chief physician. This "floor director" had absolute say on discharge of patients and also monitored each doctor's continuing education efforts. Being "on call" meant being where the authorities told you to be.

Hospitals closer to major cities and key industrial sites had the best resources. Dr. Zeleznik pointed out that the "medical director" of a given hospital had personnel authority, but all money decisions were in the hands of a non-physician political administrator.

When Dr. Zeleznik began practicing in 1958, the facilities were lavish. "They had the best of everything," he noted. But as the socialist economic system wound down, shortages began to occur. Inadequate supplies of some pharmaceuticals led to the institution of a sort of copayment system to discourage demand.

"Time and resources were always short," Dr. Zeleznik said. It wasn't uncommon for people to use "connections" to get into the best facilities. Often, knowing what the patient needed was secondary to the reality that "you could only do so much." If superiors could be convinced that a CT scan was in order for a patient, there was still a 100-mile trip to the facility.

While all these things don't seem too out of line with stories many of us have heard before about Iron Curtain medicine, Dr. Zeleznik did relate one observation that seemed truly shocking to me. On a return visit to his homeland since the fall of communism, *almost everything in the hospitals was unchanged from 30 years ago!* Shortage of resources, indeed.

And, he said, resources are *still* scarce and continue to be allocated inequitably. The best-equipped hospitals remain closer to the cities, where the politicians and their families reside.

Some of the aspects of state-run medicine, while incompatible with American sensibilities, do have their attractions. Preventive medicine was literally enforced by law. If you missed a required appointment or failed to bring in a child for immunization, the police brought you in—to the doctor, that is.

There was no malpractice liability in the sense that we know it, but, Dr. Zeleznik noted, "If a mistake was made," the offending physician could be "sent someplace unpleasant" to continue his practice.

Finally, Dr. Zeleznik gave me an account of an incident which may epitomize the chaos in this former system: "Sometimes, when I had to go out with the ambulance, I would drive, while the ambulance driver lay in back. You see, he was drunk, and I didn't trust him to drive. I did this because he had a family to provide for, and if I reported him, he would lose his job!"

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FEBRUARY 1994

February 2nd
Cardiac Pearls
Proctor W. Harvey, M.D.
Professor of Medicine
Georgetown University School of Medicine
Washington, DC

February 9th
Clinical Pathological Conference
Brian H. Fillipo, M.D.
Assistant Professor of Medicine
Director, Medical Residency Program,
Department of Medicine
Hahnemann University

Anthony Clay, D.O.
Chief Medical Resident
Department of Medicine
Hahnemann University

Jeffrey Hamilton, M.D.
Chief Medical Resident
Department of Medicine
Hahnemann University

Eliza Mandel, M.D.
Chief Medical Resident
Department of Medicine
Hahnemann University

February 16th
Pathogenesis, Immunity and Treatment of HIV Infection
Martin S. Hirsch, M.D.
Professor of Medicine
Infectious Disease Unit
Massachusetts General Hospital
Boston, MA

Bruce Walker, M.D.
Associate Professor of Medicine
Harvard Medical School
Infectious Disease Unit
Massachusetts General Hospital
Boston, MA

February 23rd
The Granulomatous Vasculitides
Gary S. Hoffman, M.D.
Chairman, Department of Rheumatic and Immunologic Diseases
Cleveland Clinic Foundation
Cleveland, OH

MARCH 1994

March 2nd
Impact of Nationwide Trials on Office Practice of Heart Disease
Robert Frye, M.D.
Professor of Medicine
Chair, Department of Internal Medicine
Cardiovascular Consultant
Mayo Clinic, Rochester, MN

March 9th
Thyroid Nodules
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology and Metabolism
University of Massachusetts Medical School
Worcester, MA

March 16th
Peripheral Vascular Disease
Nicholas P. Tsapatsaris, M.D.
Clinical Instructor of Medicine
Harvard School of Medicine
Head, Section of Vascular Medicine and Hypertension
Lahey Clinic Hospital
Burlington, MA

David Naide, M.D.
Associate Professor of Medicine
Department of Medicine
Hahnemann University

March 23rd
Osteoarthritis: Diagnosis, Medical Management, Arthroscopy and Surgical Indicators
Vincent Zarro, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Rheumatology and Immunology
Hahnemann University

Arnold Berman, M.D.
Professor and Chair
Department of Orthopaedic Surgery and Rehabilitation
Hahnemann University

Albert A. Weiss, M.D.
Associate Professor of Orthopaedic Surgery and Rehabilitation
Hahnemann University

March 30th
Monotherapy of Hypertension
Barry H. Materson, M.D.
Professor of Medicine
University of Miami School of Medicine
Associate Chief of Staff for Education
Miami VA Medical Center
Miami, FL

APRIL 1994

April 6th
Intensive Treatment of Insulin Dependent Diabetes Mellitus
Robert J. Tanenberg, M.D.
Clinical Associate Professor of Medicine
Georgetown University School of Medicine
Medical Director, Diabetic Treatment Center
Washington Hospital Center
Washington, DC

Implications for the Elderly Diabetic
Jesse Roth, M.D.
Lublin Professor of Medicine
Director, Division of Geriatric Medicine and Gerontology
Johns Hopkins School of Medicine
Baltimore, Maryland

April 13th
Coronary Artery Disease
Bernard J. Gersh, M.D.
Professor of Medicine
Chief, Division of Cardiology
Georgetown University School of Medicine
Washington, DC

April 20th
Rheumatoid Arthritis: Common vs. Rare Manifestations
Steven Berney, M.D.
Professor of Medicine
Section of Rheumatology
Temple University School of Medicine
Philadelphia, PA

April 27th
Glomerular Diseases: Present Concepts and Future Directions
William Couser, M.D.
Professor of Medicine
Head, Division of Nephrology
University of Washington School of Medicine
Seattle, WA

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

FEBRUARY 16, 1994
Treatment of HIV and Sexually Transmitted Diseases
Course Director:
John Molavi, M.D.
Guest Lecturers: Martin S. Hirsch, M.D., and Bruce Walker, M.D.

MARCH 2, 1994
Office Management of Heart Disease for the Generalist
Course Director:
Leonard S. Dreifus, M.D.
Guest Lecturer:
Robert Frye, M.D.

APRIL 6, 1994
Advances in the Treatment of Diabetes Mellitus
Course Director:
Jeffrey Miller, M.D.
Guest Lecturers: Robert Tannenberg, M.D., and Jessie Roth, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair of Medicine, Director, Continuing Medical Education for the Department of Medicine

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LETTERS TO THE EDITOR

EMPOWERING AMERICA: IMPLICATIONS OF CLINTON'S HEALTH SYSTEM REFORM PLAN

Editor's note: The author originally offered these thoughts at the December 14, 1993, Empower America health system reform meeting in Washington, DC.

We have referred to the economic and functional aspects of the Clinton health program—the disaster it represents. Today I'd like to emphasize the philosophical and psychological implications of this program.

I want to refer specifically to the massive effect upon the American people that enactment of such a program would have. It would change a free people into a dependent people—people who would be wards of the government, people who would lose their right to make the most sacred decisions [and] the right to make decisions about their mental health and physical health. It would diminish their innovativeness, and it would impoverish them financially, all of which would predispose them to have reduced resistance to further attacks on their freedom and their right of decision making.

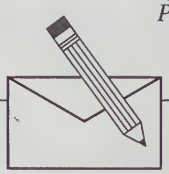
Having medical care controlled by the federal government has a profound psychological impact. I studied this in England. It diminishes the sense of self-reliance. In essence, what this attack is going to do is diminish the human base for entrepreneurial activity. It will remove people from a free life capable of making innovative decisions to a people who become wards of the government, and, as such, will be less equipped to serve as a human resource for entrepreneurial activity.

I should like to conclude by referring to the bad effects this will have on the medical profession. Innovation will disappear, spiritual impoverishment will exist due to government regulations, and a different type—an unsatisfactory type—of physician will emerge. The profession that produced Benjamin Rush and other leaders will be no more.

Thank you for this opportunity to reflect with you and share some thoughts with you. I think we should look at this thrust as a means of using health care as a tool to undermine the free structure of our society. We are going to the ramparts to protect our patients and our beloved profession from being humbled.

Join with us to help protect the entrepreneurial system.

Paul S. Friedman, MD
Philadelphia



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- *Cluster Headache and Its Variants - An Update*
  Ninan Mathew, M.D.
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- *Sex Hormones and Headache*
  Stephen D. Silberstein, M.D.
  Comprehensive Headache Center at
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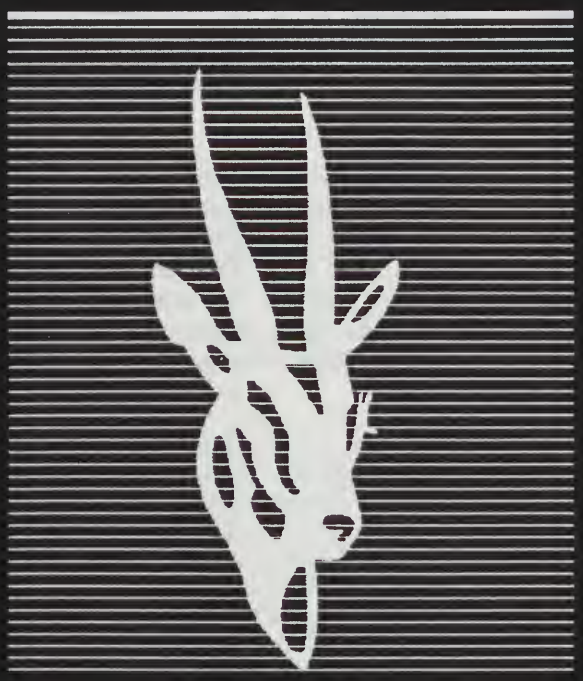

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How to Select the Right Practice Management System

Kenneth Podd

With health care "reforms" looming, physicians who plan to automate their practices—or upgrade an existing system—will want to start now. Otherwise, physicians who wait until the dust settles may find themselves facing two major projects: government mandated changes and computerization.

If you have delayed entering the computer age, don't despair. As many as 80 percent of all Pennsylvania practices are not yet taking advantage of the speed and efficiency that this technology offers physicians.

Getting the right computer hardware and software up and running in a physician's practice can be compared to the process of building a house. Before you can break ground, you must first define your needs and develop an accurate blueprint of your plans.

The key is to approach the process from a business perspective. You must operate your practice efficiently and at a profit...or you won't be in business long. Whether you are already automated or not, you will want to ask yourself several questions:

What are my requirements?

The more effort you put into defining your needs and expectations, the more cost effective the outcome will be. For example, if cash flow and reimbursement turnaround is a concern, you need to find the root cause and speed up the process. Since you can only control the systems within your own four walls, you will want to look into automating any manual procedures.

If you already have a computer, you may want to upgrade it to add speed and new features, such as electronic claims submission. What you don't want to do is perpetuate a bad system, be it manual or automated.

If you have a one- or two-person practice, you may be operating the system yourself. If there are 20 doctors in your firm, you may need a designated systems operator.

Stop to visualize how the system will fit into your organization and who will be responsible for it. What special features do you want? What is your volume of work?

Keep in mind that selecting the right software is the most important aspect of your purchase and should come before buying hardware. If you buy the computer first, it could limit your range of software choices later.

How do I determine what I need?

A good way to map out your objectives is to sit down over a weekend with pen and paper and give your expectations some thought. What do you want the system to do for you? How about billing, claims processing, scheduling, and patient records? Other functions may include streamlining administrative tasks such as compiling accounts receivable analyses, processing payroll, and generating form letters and mailing labels.

Next, determine what the system would be worth to you. For instance, would automating reduce the number of file clerks you need from five to three? Or, will it save you from having to hire additional staff? How much would that mean to you?

Will the system keep pace with your growing practice? For example, if you have a multiple-doctor practice near an expanding medical center, you may want to anticipate your future volume. Other growth factors include adding physicians and staff or opening another office.

What are the best resources for information?

The Pennsylvania Medical Society's *Practice Management Software Comparison* is a comprehensive resource which is updated annually. This 62-page guide contains an evaluation of several top software products and vendors, a glossary of computer terms, and extensive checklists to prompt you during the planning stage (see excerpt, page 14).

The guide also breaks hardware pricing into three options: a basic, low-end system; a mid-range system that will allow for →

Mr. Podd is president of Computer Resource Associates, Inc. (CRA), Camp Hill. CRA authored the Society's **Practice Management Software Comparison.**

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Physician Checklist

This checklist, excerpted from the Society's of *Practice Management Software Comparison*, poses questions for physicians to consider when evaluating software and hardware to automate their practices.

Software Considerations

Vendor Qualifications

- ☐ Where is the vendor located? Where are their regional offices?
- ☐ How long has the vendor been in the business of providing services for practice management software? Ask the vendor to provide an annual report or a financial statement.
- ☐ Is the vendor involved in any other services that would distract them from providing service to the physicians' offices?
- ☐ How does the vendor provider support and training? What is the cost for these services?
- ☐ Does the vendor assist you to convert files to the practice management system? What is the cost? How long will it take to convert the files?
- ☐ Does the vendor conduct user group meetings to discuss issues? How often?

Ease of Use

- ☐ Is the software modular? Can you purchase additional software components as your practice grows? Can the software be customized for your practice?
- ☐ Is the software menu-driven? Does it use windows, and how does the vendor define windows?
- ☐ Does the software have a help bar on the screens to assist you with commands?
- ☐ Does the software allow you to use short cuts to speed up data entry? Are function keys preprogrammed?

Processing

- ☐ What standard data files must be created, such as doctor, patient, and insurance carrier files, and procedure and diagnostic codes?
- ☐ Can changes be made to the data files from individual patient screens? Are those changes made automatically in all other areas that data is located?
- ☐ How do you search for patient information?
- ☐ Does the software have a suspend feature?
- ☐ Is word processing available through a direct link or through another interface?

Security

- ☐ Does the user have the ability to assign account numbers and define their own account classifications?
- ☐ Does the software have multiple levels of security?

Reports

- ☐ Does the software have standard reports available on the system? What are the reports? How often are the reports available?
- ☐ How easy or difficult are the reports run? Is the software unavailable to use for other purposes while the reports are running?
- ☐ Can reports be customized? Can the practice customize or create new reports, or does the vendor have to provide that service?
- ☐ If reports must be customized by the vendor, how long does that take and how long is the delay? How much does it cost?
- ☐ If the reports can be used by other practices, does the vendor share the cost among the practices they serve?

Hardware Considerations

Application

- ☐ When selecting your hardware, do you have a wide variety of manufacturers and name brands from which to choose or is your selection limited?
- ☐ Can the equipment selected be integrated to meet your needs?
- ☐ Is the hardware produced by one of the top 10 manufacturers in the country?
- ☐ Does the vendor have a legal, contractual agreement with the manufacturer? If not, how is the hardware acquired?
- ☐ How easily and quickly will the practice be functional on the new system?
- ☐ How available is the vendor during this transition to the new system? Will you be charged extra for this service?
- ☐ What is the charge for installation and/or cabling?
- ☐ Is there an additional charge to configure the system if the hardware was purchased through a separate hardware vendor?

Storage and Memory

- ☐ What is the storage capacity of the current system (in megabytes)? Can the memory be expanded?
- ☐ What happens if this proves inadequate? What are the procedures if this limit is reached and additional storage capacity is required?
- ☐ How is business resumption handled in the case of a disaster? Off-site backups?
- ☐ What type of disk drives does the system possess?
- ☐ Does the vendor guarantee the recommended memory requirements? Does the vendor calculate the future expansion of the practice when recommending hardware?
- ☐ Does the vendor provide any projections for the size and capacity of the hardware needed?

Speed

- ☐ What is the processing speed of the system?
- ☐ How efficiently does it handle using the peripheral devices (printers, disk drives, monitors, etc.)? Is the access time for these devices substantial? Will the peripherals slow down the processing speed?
- ☐ Does the vendor provide any recommended limit to the amount of data on the system before the speed is impacted?

Maintenance

- ☐ Does the vendor have a legal, contractual service agreement with the manufacturer? If not, how is hardware servicing handled? Do they do it themselves? Do they recommend a third-party maintenance company?
- ☐ Where are the service representatives located? Is there a local service center close by?
- ☐ What is the vendor's policy on repairs and replacement?
- ☐ What are the vendor's guarantees for down time? How quickly will they restore the system?
- ☐ What are the vendor's requirements for back ups? Are there any guarantees?
- ☐ What is the response time to your site after the service call is placed? Is this response time guaranteed?
- ☐ What repairs are included under the service contract? Is preventative maintenance included or must this be purchased separately? Are software and/or system enhancements included?
- ☐ Are there any additional fees required for certain maintenance operations?
- ☐ Are there any warranties on the equipment?

Future

- ☐ What kind of long-range growth plan do they offer?
- ☐ Are there expansion capabilities with the current system?
- ☐ Do they have a documented list of their most recent system enhancements and their projections for future enhancements available for your review?
- ☐ What is required to upgrade the system? New hardware? New software?
- ☐ What is the proposed cost, if any, for upgrading the system?

a limited amount of expansion; and a top-of-the-line system that can be more extensively expanded. In the 1994 *Practice Management Software Comparison*, hardware pricing ranges from $1,300 to $2,200.

The guide's selection on software vendor comparison includes an analysis of practice management/electronic claims submission vendors offering quality products and services, and who passed the evaluation criteria, including reference checks. For ordering information, see page 17.

Your initial research may also include reading professional journals, researching directories in your local library, and talking to vendors and retailers. Another good source of information will be your peers. Find out what they have done and how much it cost; ask them what is good or bad about the system they chose. Pennsylvania Blue Shield-Electronic Services also provides limited information on software vendors (800-992-0246).

How do I get my plan off the ground?

Start by defining your acquisition plan, accessing the skills you need to implement the plan, and scaling your efforts appropriately. Consider hiring a consultant for the skills you may not have, such as setting up local area networks.

List the activities you want the system to perform and define your staff members' responsibilities. Determine your approximate start-up, installation, and supply costs, and budget for recurring expenses. Don't forget to factor in data entry time or →

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data conversion costs if you already store information on a computer.

What factors should I consider when establishing a budget for computerization?
It's not necessary to spend $10,000 for a consultant if you are just purchasing your first personal computer (PC). Then again, even the smallest practice will need to spend $5,000 to $10,000 for a basic system. Software prices can literally range from $99 to $1 million.

As you aim for the best quality for the best price, the size, speed, and number of components you need will all affect your costs. Once you have established your price range, however, you can narrow your choices.

What other expenses can I expect?
Understand that there is much more to automating than simply buying the hardware and software. You need to consider maintenance, upgrades, support staff, insurance, backups, off-site storage, and consumable supplies such as paper, ribbons or toner, tapes, or diskettes.

What aspects should I keep in mind in addition to price?
Don't forget to consider the layout and traffic pattern of your office. Think about where the system will be used and whether printer noise will be a problem.

Your storage and memory needs will affect the cost, installation, and speed of operation. Don't forget to determine the processes and costs involved in expanding the capabilities of your system in the future.

Prepare your staff for automation: Talk about what the system can do to help in the office. Address staff concerns and natural anxieties associated with using a new system. Find out how much training and support prospective vendors offer—depending on your staff, you may need additional training or very little.

How can I avoid "getting burned?"
For your own protection, you will want to issue a request for proposal (RFP) that describes your needs, defines your requirements, and provides for selection criteria. This is as simple as drafting a letter or a list of questions that every vendor must answer uniformly.

An RFP is important because it defines your expectations and becomes a legal document you can enforce if you are not satisfied. There have been some real horror stories of people buying expensive systems that do not do what the customers wanted. If you have nothing in writing, you have no recourse.

What should my RFP include?
Start with an introduction and a statement of the problem you want solved. List your requirements in the areas of business function, technical, economic, and vendor performance. Include your selection criteria and mandatory needs, and don't forget to state your financial and reference requirements.

How do I evaluate the vendor proposals?
Standardization is the key. You want to be able to compare "apples to apples" to the best degree possible.

Ask for a full set of costs and a detailed background on each firm. Request references and be sure to check them. Ideally, try to verify their performance with someone other than those listed, even though this is hard to do.

Your goal is to identify a firm that is well-established, adequately staffed, and available for future support. Begin by asking vendors to provide you with the name of a practice that is using the software you are interested in, visiting the practice while the equipment is in use, and speaking with the physicians and office manager about their system's performance.

Keep in mind what you want and how much you are willing to spend; then, select three finalists and ask for demonstrations.

What can I expect from a demonstration?
Have each of the three contenders come in one at a time and set up their systems. In the ideal world you would use each system for a few months in your own environment and evaluate them. (Yes, this will take time.)

At the minimum, you need to be able to determine if the system meets all of the functional aspects of what you want it to do. You have to ask yourself if this is a good technology or company to invest in, and weigh whether it is leading edge or likely to become obsolete. Each will have its own set of advantages and disadvantages.

You should set the agenda and control the sales demonstrations. Look at what you want instead of allowing the salespeople to present what they want to show you. Then, rank the vendors, and start negotiating.

How much leeway do I have during negotiations?
Everything is negotiable: price, training, installation, maintenance fees, extended

warranties, data conversion, and installation.

What else do I need to think about?
Prepare your implementation procedures based on your earlier plan. This will include site preparation, personnel assignments, training, acceptance testing, and integration planning. This may involve multiple vendors, so be sure to test all aspects of the system.

How can I protect my interests at this point?
It is important to have written agreements concerning the hardware purchase and maintenance, and the software licensing or purchase and maintenance. Incorporate all sales literature and correspondence into your agreement. Since this purchase represents substantial investment, it's best to hire a lawyer for this process. Remember, the sales representative will be telling you how smoothly things will go. However, things almost never go the way everyone wants them to go.

Don't forget to keep a written record of your expectations and all vendor promises, including a comprehensive definition of vendor service and support. Test for response time (volume), functionality (does it do everything you want it to do?), reliability, and disaster recovery.

It is common practice to withhold 10 percent to 15 percent of the purchase price until you are fully satisfied with the setup.

What is the most important step I should take right now?
Make sure you set a deadline for implementing your plan or—rest assured—it will never get done.

How to order the software comparison

The Pennsylvania Medical Society's *Practice Management Software Comparison* is a 62-page guide which is updated annually and contains an evaluation of several top software products and vendors, a glossary of computer terms, and extensive checklists to prompt you during the planning stage.

The guide is free to State Society members, and available for $35 to nonmember physicians and $50 to others. To order the most current edition, call the Society's Department of Physician Services at (800) 228-7823 or (717) 558-7750.

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The Concept of Futility

As technology has expanded our ability to prolong physical existence, the futility of continuing medical treatment in certain cases has come under increasing debate. The articles that follow present two sides of the argument: one maintaining that the decision about futility should remain with physicians, the other urging that physicians offer care in certain circumstances no matter what their personal views. These point-counterpoint articles (see pages 20 and 26) stimulate further discussion and thought on futility—a concept that has become increasingly important as the health care system assesses its use of medical resources.

Futile Care: Physicians Should Not Be Allowed to Refuse to Treat

Robert M. Veatch, PhD, and Carol Mason Spicer

Eighteen years after the era of Karen Ann Quinlan, the debate over futile care has shifted. Now some patients are asking for treatment that caregivers believe to be useless. In virtually all cases of so-called futile care, the real disagreement is not over whether a treatment will produce an effect; it is over whether some agreed-on potential effect is of any value.

An obvious reason to resist providing care believed to be futile is that it appears to consume scarce resources and therefore burden others. However, for care that affects the dying trajectory but appears to most of us to offer no benefit, the proper course is for society—not clinicians—to cut patients off.

Under certain circumstances patients should have the right to receive life-prolonging care from their clinicians, provided it is equitably funded, even if the clinicians believe the care is futile and even if it violates their consciences to provide it. Society is not in a position to override a competent patient who prefers to live even if life prolongation is burdensome. For incompetent patients, if a clinician believes a treatment is actually hurting a patient significantly, he or she may appeal to a court to have it stopped.

A society that forces people to die against their will produces more offense than one that forces health care providers to provide services that violate their consciences. And medical professionals have a social contract with society to control the use of medical, life-prolonging technologies. Thus clinicians should be obliged to render the desired care if at least the following conditions exist: an ongoing patient-physician relationship, no colleague capable and willing to take the case, a clinician competent to provide the desired service, equitable funding, and the care is predictably life-prolonging. (*See article, page 20.*)

Patients Do Not Have a Right to Demand Medically Useless Treatment

James F. Drane, PhD, and John L. Coulehan, MD

Traditionally, applying the principle that physicians do not provide treatments when the interventions at their disposal do not produce medical benefits has been relatively straightforward. However, with the growing importance of patient autonomy and informed consent in treatment decisions, ethicists must now balance this principle with the principle of patient self-determination.

A patient's right to choose or refuse treatment is limited by the physician's right (and duty) to practice medicine responsibly. Bizarre or destructive choices made by a patient are not sacrosanct simply because the patient made them. In some cases, physicians may choose not to act on patient decisions that appear to be unreasonably destructive.

Physicians also have a right to refuse to provide futile treatments (i.e., interventions that might be physiologically effective in some sense but cannot benefit a patient). Patients themselves have a right to provide input into what would constitute a "benefit" for them, but physicians should be able to decide when a particular treatment is futile based on their knowledge of the treatment's effects and its likely impact on a patient's quality of life.

Ethical rules covering futility can be developed based on socially sanctioned standards of rationality and traditional physician-based values. Clarifying the concept of futility and establishing defensible ethical policies covering futility are important steps toward eliminating unhelpful, medically inappropriate practices. (*See article, page 26.*)

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Futile Care: Physicians Should Not Be Allowed to Refuse to Treat

Robert M. Veatch, PhD
Carol Mason Spicer

In the first article of this point-counterpoint series addressing the futility of care, the authors urge physicians to offer care in certain circumstances no matter what their personal views.

Americans are in the midst of a great reversal in medical ethics. We have come a long way from the era of Karen Ann Quinlan, when patients and their families were desperately trying to get treatment stopped. At that time clinicians believed they had a moral duty to treat to the last gasp. The outcome of that debate was a patients' rights movement, which gave patients the right to refuse medical treatment, even if refusal would lead to death. It also gave families the right and the responsibility to function as surrogates for patients, trying to do what patients would have wanted, when patients' wishes are known, and trying to determine patients' best interests in cases where they are not.

Now, 18 years later, the debate has shifted. Some patients are asking for treatment that some caregivers believe to be useless. Some patients insist on receiving what physicians believe to be "futile care," others are arguing that physicians should have the right to refuse to provide care they deem futile.[1]

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Dr. Veatch is director and professor of ethics, and Ms. Spicer is editor,* Kennedy Institute of Ethics Journal, *Kennedy Institute of Ethics, Georgetown University, Washington, DC.

Medically inappropriate: a misnomer

On December 14, 1989, 86-year-old Helga Wanglie slipped on a rug and broke her hip.[2] She was treated at Hennepin County Medical Center in Minneapolis. She developed a series of respiratory tract infections and was placed on a respirator from which physicians were unable to wean her. She was transferred to a nursing home, where she suffered cardiac arrest and was left in a persistent vegetative state (PVS), on a ventilator and nasogastric tube. The health care team's unanimous conclusion was that the treatment was futile and "medically inappropriate."

But what can medically inappropriate mean here? It is morally reasonable to support the withdrawal of ventilators or even feeding tubes in such cases. But calling the inappropriateness "medical" tells us absolutely nothing and, in fact, perpetuates a serious philosophical mistake that has horrendous implications.

If continuing treatment is inappropriate, it is inappropriate religiously, philosophically, or morally, but medically the treatment has a definite effect. It clearly prolongs her life and is therefore efficacious.

Two basic distinctions

To understand the debate over futile care, two basic distinctions must be made:

- a critical distinction between physiologically futile care and "normatively futile care"; and
- a distinction between denying so-called futile care on the basis of allocating scarce resources and denying it on the grounds that it violates caregivers' integrity.

Physiological Versus Normative Futility: Some interventions labeled futile are really without physical effect. This is what Stuart J. Youngner has called "physiologically futile treatment."[3] Such treatment will not produce the effect sought by the one insisting on it. This must be distinguished from care that has the anticipated effect but is believed by someone to be of no net benefit. We will call this second kind of futility "normative futility" because it involves a value judgment that the effect is of no benefit.

Physiological futility is more or less a question of medical science. We say "more or less" because every scientific question involves some value judgments (e.g., a choice of p values and a choice of the concepts used to describe the effects). In rare instances, clinicians will disagree over the facts because of these hidden value disputes. Lay persons may also disagree with clinicians over such matters. To the extent that they do, it is not irrational for society to require care that

physicians have deemed physiologically futile. That occurs only in unusual circumstances, however. In virtually all cases of so-called futile care, the real disagreement is not over whether a treatment will produce an effect; it is over whether some agreed-on potential effect is of any value.

To distinguish physiological from normative futility, ask the question: Is the disagreement over the science (the judgment about what the effect will be) or over the value of the agreed-on outcome? We can presume that clinicians are correct on the science, but also that they have no special claim to expertise on the value of the outcomes.

Rationing Versus Integrity: A second distinction is also important. There are two separate reasons to be concerned about patient demands for care deemed futile: issues of rationing and of caregivers' integrity.

First, an obvious reason to resist providing care believed to be futile (in either sense) is that it appears to consume scarce resources and therefore burden others. Our communal resources are inevitably scarce. Surely, if a treatment's benefits are so debatable that most of us consider them to be nonexistent, that is an obvious place to cut. But that does not mean it is a clinician's role to do the cutting.

We have acknowledged the legitimacy and necessity of rationing health care,[4] provided it is done equitably and with full public participation in decisions. But historically the clinician's job has been to help patients, not to act as society's cost-containment agent. This gatekeeping role must be someone else's task. Just like a defense attorney's role in the legal system is to advocate for a client—even an unworthy client—a clinician's job in the medical system is to advocate for his or her patient.

We agree that care without effect should not be funded on scientific grounds. A clinician should not be permitted to authorize treatments that he or she is convinced will not produce the effect a patient or surrogate seeks. In fact, insurers who receive requests for reimbursement for such care ought not to pay for it. However, for care that affects the dying trajectory but seems to most of us to offer no benefit, the proper course is for society—not clinicians—to cut patients off. Subscribers to insurance should have a strong interest in limiting care that offers little or no benefit and should agree to exclude such coverage from their plans.

For example, most Americans apparently believe that providing continued, long-term life support serves no purpose for a patient who is in a PVS. Insurers or health maintenance organizations (HMOs) should ask whether subscribers want to include long-term support for PVS patients in their coverage. Insurers should be able to explain what premiums would be if coverage for PVS treatment is and is not included. Insurers should not care whether subscribers vote PVS treatment in or out as long as they set an appropriately larger premium if such treatment is included.

We believe that most subscribers would vote PVS treatment out. The minority of subscribers who have an interest in such care can decide to buy supplemental insurance (a PVS rider) or to pay for the care out of pocket. If the insured group votes to include the coverage, or if individuals self-fund or buy supplemental coverage, then there is no unfairness to society as a whole. We can call this "equitable funding."

Helga Wanglie was an HMO member. HMO administrators should have asked her and her fellow subscribers whether they wanted to fund care for PVS patients. However, the HMO was explicit in its willingness to provide the funding for the care. There was thus no economic reason why the hospital or the individual physicians responsible for Helga Wanglie's care should have felt compelled to resist on grounds of allocation or resources. Also, at the time there were no noneconomic demands—a scarcity of time or of beds—that would force a rationing decision. Had there been such scarcities, the institution would have had a moral obligation to make allocational choices.

Concern about a scarcity of resources, however, is increasingly not the reason physicians want to limit care they deem futile. More commonly physicians want to protect the "integrity" of the physician who feels that it violates professional norms to deliver care that will do no good. We argue that under certain circumstances patients should have a right to receive life-prolonging care from their clinicians, provided it is equitably funded, even if the clinicians believe the care is futile and even if it violates their consciences to provide it.

This is a serious conflict, and we do not endorse such a position lightly. But clearly in some cases a physician must be obliged to violate his or her conscience. Consider, for example, someone raised as a racist who sincerely believes that it is wrong to provide medical treatment for racial minorities. The mere fact that the prejudiced belief is held sincerely surely would not permit the physician to refuse to treat all members of minority groups.

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"We argue that under certain circumstances patients should have a right to receive life-prolonging care from their clinicians, provided it is equitably funded, even if the clinicians believe the care is futile and even if it violates their consciences to provide it."

It is similarly clear that patients cannot be allowed to receive any medical treatment that they happen to crave. Certain conditions will have to be met before the duty to provide care deemed futile will prevail. We will detail these conditions later in this article, but first we will explain the moral reasons why some patients may have a legitimate claim to care that physicians believe will do no good.

Moral complexities surrounding a duty to treat

Let us return to the case of Helga Wanglie. She and her husband were members of the right-to-life movement. Previously she had told family members that she would never want anything done to shorten her life. Her husband is quoted as saying, "I'm a pro-lifer; I take the position that human life is sacred."[5] He said that his wife of 53 years felt the same way. Their daughter agreed.

"A patient must be conscious to be burdened in any real sense. It is difficult to understand how Helga Wanglie or Karen Quinlan can be burdened by continued life support."

There was no dispute about the medical facts. The physicians and the Wanglie family agreed that she was permanently unconscious, that providing a ventilator and nasogastric tube would prolong her life, albeit in a vegetative state. The only question was the value of vegetative life.

A Comparison with Quinlan: Compare this "futile care" case with the classic treatment refusal case of Karen Ann Quinlan, the young woman who in 1975 suffered a respiratory arrest that left her in a PVS.[6] Her physician, Robert Morse, was absolutely convinced that a ventilator believed necessary to preserve her life was providing benefit. He considered it "medically appropriate," claiming, probably incorrectly, that letting a permanently vegetative patient die violated the professional standard of the time.

The most critical issue in the court battle was whether a clinician's judgment about benefit for a patient could take precedence over a patient's or surrogate's assessment of benefit. Karen Quinlan's family and lawyer successfully argued that a professional consensus about whether an effective treatment was beneficial was irrelevant. Her father was, in effect, given the power to decide whether his daughter would consider this treatment beneficial.

The Quinlan and Wanglie cases, despite the seemingly opposite values of the decision makers, are similar in that both involved an assessment of the value of vegetative life. This assessment is fundamentally not a technical medical matter. Different people with different beliefs and values can come to different conclusions about whether ventilating a permanently vegetative patient is a benefit. When a patient is competent, he or she has the right to decide. When the patient is not competent, then the designated surrogate has the responsibility to try to determine what is best.

The two types of cases differ, however, in that the moral issue confronting physicians in futile care cases is whether patients or surrogates who make the decision that such care serves a worthwhile purpose have a right to insist that it be provided and, if so, on what basis.

Autonomy Problem: Some defenders of the right to access make the mistake of claiming that the moral principle of autonomy confers that right. Autonomy gives a patient a right to refuse treatment. By extension, it even gives family members a limited right to decline treatment on a patient's behalf. But that does not imply that autonomy can give the patient a right of access. There is a lack of symmetry. Autonomy is a liberty right. A patient has a right to cancel the patient-physician relationship and, at least metaphorically, walk away. But in so far as autonomy is relevant, it also should give a provider the right to sever the relationship. Autonomy cannot be the basis of the claim to a right to access.

Burden of Futile Care: A second complexity in the argument concerns the possibility that acting on the demand for care deemed futile might impose excessive burdens on a patient. Clinicians evaluate some care not only as providing no benefit, but as actually harming a patient. But if harm refers to pain and suffering, a patient must at least be conscious for harm to occur. It is difficult to understand how Helga Wanglie or Karen Quinlan can be burdened by continued life support. There may well be moral offense if, for example, the life support is administered against a patient's wishes, but a patient must be conscious to be burdened in any real sense.

If a patient is mentally alert, he or she could perceive burden, but if the patient is mentally competent, it is the patient's judgment of burdens and benefits that must prevail. The patient is the one who will suffer the burden and die if treatment is forgone. Surely, society is not in a position to override a competent patient who prefers to live even if life prolongation is burdensome. Only a monstrous society would permit a physician to impose death on a patient who wants to live because the physician believes the patient would be better off dead.

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3:30-4:00	The coronary artery bypass surgery: Candidates who are best suitable and least suitable for this procedure	*W. Clark Hargrove, III, M.D.*
4:00-5:00	Case Presentation	*Steven A. Roberts, M.D.*
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The same rationale applies to persons who are mentally incompetent and who have expressed their wishes while competent, but what about those who have never expressed their wishes while competent? If a clinician believes treatment is actually hurting a patient significantly, he or she may appeal to a court to have it stopped.

Courts routinely override parents and guardians who refuse treatment when the refusal seems to harm a patient (e.g., Jehovah's Witness parents who refuse lifesaving blood for their children).[7] No court has yet ruled that parents or guardians can be guilty of abuse by insisting on futile care for a ward who is made to suffer by continuing treatment that is not only futile, but, on balance, gravely burdensome. Someday soon one may. But a judge, not a clinician, should determine the care to be unacceptable. Even if a clinician believes there is a burden on an incompetent patient, he or she should continue treatment until authorized to stop.[8]

"Effective, nonburdensome, life-prolonging care is always morally required if a patient or surrogate desires it."

Consider the case of Baby L.[9] She had fetal hydronephrosis and oligohydramnios, leaving her blind, deaf, and quadriplegic, with a gastrostomy and recurrent pneumonia. At two years of age she had the mental status of a three-month-old and had had four cardiac arrests. But she was conscious and could feel pain. Her mother insisted on life support, but the medical staff opposed mechanical ventilation and cardiovascular support, which they thought was "futile" and "inhumane."

The treatment was clearly preserving Baby L's life. She had lived for more than two years. The real issue was whether it was normatively futile.

There are good reasons why this treatment should be considered disproportionally burdensome. Nevertheless, a clinician has no *medical* basis for deciding that the effective treatment does more harm than good. Only a public agency with due process has that authority. If a clinician believes that an incompetent patient is being harmed by futile care demanded by a surrogate, the clinician's duty is to try to get the surrogate overridden.

John J. Paris and colleagues treat the Baby L case as a paradigm futile-care case. However, this is a special case. The patient has never been competent to evaluate the burdens, and the burdens could well exceed the benefits. But even in these circumstances the clinicians cannot withdraw the life support on their own. It is appropriate and reasonable to try to get a court order to stop, but this is different from simply deciding to overrule the mother's judgment about the burdens and benefits of the life support.

Futile care for patients who are not being harmed

Cases involving burden to incompetent patients are really not the essence of the futile care debate, however. The real issue is futile care for patients who are not being harmed. This is true futile care (i.e., care that produces neither benefits nor burdens for a patient). For the moment let us simplify the analysis by limiting the discussion to interventions that will predictably prolong life.

Clinicians always have the right to withdraw from a case, just as a competent patient might, provided someone else is willing to take the case. It is in neither a patient's nor a physician's interest to insist that the original physician continue. But if no colleague is willing to step forward, the treatment is life prolonging, and the treatment will not be burdensome, then a licensed professional responsible for and capable of providing the care has a duty to provide it even if he or she is morally opposed. Otherwise that clinician would have to argue that the patient is better off dead even though the patient is not being injured and even though the patient or surrogate disagrees. Effective, nonburdensome, life-prolonging care is always morally required if a patient or surrogate desires it.

But why should physician autonomy be violated in this one case when generally patient autonomy should not be violated? Two arguments can be offered: the argument from offense and the argument from contract.

Argument from Offense: If a patient or surrogate is demanding life-prolonging care that his or her clinician believes is futile and a violation of his or her integrity to provide, we have a head-on clash between a patient's or surrogate's choice for life and the provider's autonomy. A society that forces people to die against their will produces more offense than one that forces health care providers to provide services that violate their consciences. If society must offend, the lesser offense is preferred.

Argument from Contract: The second argument rests on the notion of the social contract or covenant between medical professionals and society. Licensed pro-

fessionals are the only members of society licensed to control the use of medical, life-prolonging technologies. When they accept licensure, they accept a public trust to use their monopoly on medical knowledge to preserve lives when the appropriate decision makers want them preserved.

Imagine that society is contemplating creating monopoly control over certain life-prolonging technologies. Further, imagine that there will be cases in which a minority desperately wants these technologies used while a majority does not see any value in their use. Finally, imagine that we cannot know whether we will be in the majority or the minority. We believe a rational society will extract, as a condition of licensure, a promise that the clinician will use these technologies for people who want them.

Of course, some conditions would be attached to such a promise. These might include:

1. An ongoing patient-physician relationship.
2. No colleague capable and willing to take the case.
3. A clinician competent to provide the desired service.
4. Equitable funding.
5. The care being predictably life prolonging.

At least if all these conditions were met, we believe clinicians would be obliged to render the desired care. All these conditions were met in the Wanglie case. Once the court determined that Helga Wanglie's husband was the proper surrogate, physicians wisely acknowledged their duty to provide the care they believed was futile even though it violated their sense of professional integrity. Once one realizes that the decision to forgo effective, life-prolonging care is a moral choice rather than a technical one, it seems hard to deny the right of the minority to access. If we have created a monopoly in the use of that technology, we would be wise to insist that minority interests be protected by ensuring that holders of minority views can have their lives prolonged. The alternative is to permit physicians to decide that a patient would be better off dead even though the patient is not being burdened and even though the patient or surrogate believes the life should be preserved.

Non-life-prolonging fundamental care

What we have said thus far is limited to care that can be expected to prolong life effectively, at least for a length of time that a patient or surrogate considers worthwhile. The argument for the duty to provide care deemed futile clearly does not extend to all non-life-prolonging treatments that may be of interest to the patient. Some patients' demands are too offensive or too trivial to make them part of the contract between professionals and society. For example, a patient's demand that a surgeon amputate a healthy limb would not have to be honored.

On the other hand, some care that does not prolong life may still be considered so fundamental that physicians would have a duty to provide it. Consider, for example, medication to relieve severe chronic pain. Some physicians may sincerely believe that providing such medication is wrong, for instance, because it may shorten a patient's life. A physician may consider the use of such risky medication immoral, even though Catholic moral theology and much secular thought acknowledges the legitimacy of risking the indirect side effects in such cases. Even if a physician is sincerely opposed, however, he or she may well be expected by society to administer the pain relief, provided no other physician will take the case.

The key is that some interests of patients and surrogates may be recognized as fundamental. Even if a majority would not consider the treatment worth pursuing, that majority might recognize the importance of the minority's claim. Life-prolonging care is fundamental in this way; certain non-life-prolonging care may be as well. If the care is perceived as fundamental, then it should be part of the social covenant between society and the profession. In such cases, as in ones involving life-prolonging treatment, if 1) there is an ongoing patient-physician relationship, 2) no other physician will take the case, 3) the clinician is competent to provide the care, and 4) the funding is equitable, the licensed professional who is given a monopoly over the control of life should be expected to promise to use that technology when patients or surrogates ask for it. ⬡

References available upon request.

Some of the material in this article appears in the authors' article, "Medically Futile Care: The Role of the Physician in Setting Limits," *American Journal of Law and Medicine*, 18(1,2):15-36, 1992.

The Concept of Futility: Patients Do Not Have a Right to Demand Medically Useless Treatment

James F. Drane, PhD
John L. Coulehan, MD

In the second article of this point-counterpoint series addressing the futility of care, the authors maintain that the decision about futility should remain with physicians.

"I will use the dieta [treatment] to help the sick according to my ability and judgement, but never with a view to injury and wrongdoing."

—From the Hippocratic Oath

The norm of beneficence, which directs physicians to apply their insights and techniques for patients' good, has been a basic principle of medical ethics for 2,500 years. Under this principle, physicians do not provide treatments when the interventions at their disposal do not produce medical benefits.

Traditionally, when medical treatment was provided in a paternalistic style (i.e., when physicians made treatment choices without asking their patients' permission), the application of the norm of beneficence was relatively straightforward. Today, however, an ethic of patient autonomy and informed consent has replaced the traditional paternalistic approach that gave maximum authority (as well as responsibility) to the physician. Thus the principle of beneficence must now be balanced with the principle of patient self-determination.

The question we address here is whether the patient self-determination requirement can compel physicians to make futile interventions—treatments they know provide no benefits and therefore violate the beneficence principle. The futility issue can be a key ethical consideration in cases in which the principles of physician beneficence and patient autonomy appear to conflict.

Physician beneficence and patient autonomy

Patient autonomy, or self-determination, is first a right to refuse treatment and then a right to choose from among medically justifiable options. It is not a right to demand treatment. Put differently, a patient's right to choose or refuse treatment is limited by the physician's right (and duty) to practice medicine responsibly. The belief that medical professionals ought to respect the informed choices of patients or their surrogates arises, first, out of respect for autonomy. But it is also a consequence of the realization that beneficence is ordinarily best served when patients can judge for themselves the impact of various treatment options on their life plans and personal goals.

Although patients ordinarily choose a course of action they judge to be in their best interests, sometimes they make bizarre and destructive choices. Such irrational choices are not sacrosanct simply because the patient made them. Commitment to beneficence demands at least that physicians try to understand patients' intent and motivation and to influence them to make a rational decision. In some cases, physicians may choose not to act on patient decisions that appear to be unreasonably destructive.[1]

Professional discretion and judgment are always part of the clinical decision-making process. Physicians should communicate with patients throughout the treatment process and must monitor patient participation in medical decision making. Physicians, in effect, make judgments about the nature and relevance of patient values, in addition to making value judgments about medical issues. They evaluate patient competency based on patients' responses to medical interventions, their thoughts about their medical situations, and their reasons for deciding one way or the other.

To suggest that doctors abandon all such judgments and then ignore the personal harm resulting from a risky or useless intervention "because the patient asked for it" is to subvert the core of medical professionalism.[2] Medical judgments

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are never value free. However, physicians should be aware of the value components of their decisions and be able to justify them.[3]

Value commitments (e.g., relieve suffering, do not assist in suicide, do not harm patients, do not cause suffering without proportionate benefit) inform most physician decisions. These professional standards reflect medical values and guide judgments about the appropriateness of a medical intervention for a particular patient. Among these standards should be the following: Do not offer futile treatments as medical options.[4]

The concept of futility

The concept of futility has had historic importance in medicine. For Hippocratic physicians, attempting a futile treatment was a display of ignorance.[5] Contemporary ethical standards published by the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) show continuity with this tradition: "Physicians should not provide or seek compensation for services that are known to be unnecessary or worthless."[6]

Because the concept of futility has been consistently confused with other concepts and categories, some distinctions are in order. A futile intervention is different from one that is *harmful* (e.g., poison), *ineffective* (like cough drops for a lymphoma), or *impossible* (like a self-administered coronary bypass). Nor is a futile intervention the same as a treatment whose goal is to achieve uncommon or unusual outcomes, like the long-term survival of a patient with metastatic pancreatic cancer. The issue of whether a situation is deemed hopeless is also irrelevant to the issue of futility, since hope is a subjective disposition that can be maintained even in the face of impossible situations. Finally, while certain treatments in certain situations are simply too expensive for a family or a society, it does not help to refer to these as economically futile.[7] Much of the confusion about futility arises when authors claim to be talking about this concept but are actually addressing very different issues.

Some clarity can be achieved by distinguishing futility from ineffectiveness. In contemporary medicine, ineffectiveness is determined statistically on the basis of accepted scientific standards. A 0 percent success rate in 1,000 trials, for example, would constitute an ineffective treatment. Categorizing a treatment as ineffective, however, does not imply 100 percent certainty about its outcome, because the next trial might reveal an effect not evident in the previous 1,000. Another closely related category is *highly improbable*. In this case, a given treatment may have been successful on a few occasions, but its success can neither be scientifically explained nor reliably predicted.

A futile treatment differs from an ineffective or highly improbable treatment in that it is always somewhat effective (e.g., a temperature is lowered or raised, lung function is sustained). However, futile treatments are fruitless because they do not achieve "worth" in the sense of meeting a patient's medical goal or providing a true personal benefit.[8] Doctor-patient communication is sometimes required to know that personal patient benefit cannot be attained, but at other times it is obvious (with the permanently unconscious or dying).

In light of the above distinctions, a medically futile treatment can be more accurately defined as an action, intervention, or procedure that might be physiologically effective in a given case, but cannot benefit the patient, no matter how often it is repeated. A futile treatment is not ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient's condition) or the condition of the patient makes it futile.[9]

Futility and patient consent

Attempts to determine personal patient benefit or acceptable quality of life ordinarily depend on patient input. Should all futility questions then be left up to patients or surrogates? Do futility decisions fall outside physician discretion?

Some medical ethicists think so.[10] We take the opposite position. Determining futility entails evaluations of a medical intervention and a patient's medical status that only a physician can make. Physicians know, for example, that cardiopulmonary resuscitation (CPR) can do no good for terminal patients whose cardiac arrest relates to the natural progression of their disease.[11] Even if the patient is incompetent and no family is available to provide input about his or her preferences, physicians in consultation with other team members can decide that a particular treatment cannot achieve medical goals, values, or objectives.

The discussion of futile treatments with patients and family is altogether appropriate,[12] except when such a discussion would cause added and unbearable burden to an already difficult situation. The objective of such discussions is to help patients and families understand the clinical situation and why a particular interven-

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"For Hippocratic physicians, attempting a futile treatment was a display of ignorance."

tion is not an option. The physician should be as responsive as possible to the patient's physical, emotional, and spiritual needs, but neither consent nor refusal should be requested.

The AMA's Council on Ethical and Judicial Affairs upheld this view in deciding that physicians need not seek consent for a do-not-resuscitate order when CPR is deemed futile.[13] Informed consent is a process by which competent patients make judgments about real options and, as such, supposes socially sanctioned standards of rationality. Although some individuals may operate outside these rational limits (e.g., by demanding what is useless or futile), they cannot insist that professional standards and public policies support their preferences.

"The current situation, in which patients or their surrogates are commonly (but falsely) led to believe that futile treatments are medically acceptable, actually does violence to the principle of autonomy, as well as to beneficence."

Beneficence requires that doctors do only what is medically helpful. Individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence. The key to the futility debate is identifying what constitutes legitimate medical help. Like most contemporary medical ethics problems, determining futility requires balancing the values and goals of medicine with the goals and values of patients, taking into consideration the uncertainty inherent in making predictive medical judgments.[14] Inevitably there will be some differences among physicians in judging uncertainty and the helpfulness of specific treatments.[15]

Ethical rules, rationality, and beneficence

Ethical rules covering futility can be developed based on socially sanctioned standards of rationality and on traditional physician-based values. Several such rules are suggested at the end of this article.

Some ethicists argue that allowing physicians to not offer futile treatment to patients would constitute an unacceptable return to paternalistic medical practice. They hold, in effect, that physician assessments of benefit are always suspect, and that benefit is so inherently subjective that even the most idiosyncratic patient or surrogate choices must be honored.

Obviously, a physician's decision will reflect his or her values. A professional physician's value judgment, however, will be neither random nor individualistic. If doubt is raised about an instance of physician decision making, the decision can be reviewed by an ethics committee to make sure that beneficence and not some selfish value is operating.

An extreme autonomy position ignores the fact that a well-established "best interest" standard assumes both a connectedness of the patient to family and physician and a communication process that allows surrogates to decide based on objective, community-based best interest standards.[16] The existence of such standards and their relevance to medical decision making can be seen from the fact that five state courts recently permitted foregoing life supports for incompetent patients who had never expressed a previous preference.[17] Without available subjective preference, the decisions were made on physicians' and families' objective evaluations of a patient's best interest.

The current situation, in which patients or their surrogates are commonly (but falsely) led to believe that futile treatments are medically acceptable, actually does violence to the principle of autonomy, as well as to beneficence. It creates a sphere of decision making where (rationally) none exists and, thus, seems intrinsically deceptive.

Frequently, physicians believe they have done their duty when they allow patients or families to make difficult treatment decisions, even when they have not explained sufficiently the medical and human consequences of the options. In such cases the focus on patient choice diminishes the physician's commitment to professional duty and patient well-being. Thus we believe that respect for autonomy and beneficence is impaired by allowing patients to choose futile treatments or by claiming that the concept of futility is so inherently subjective that it is useless.

Weakening futility as a workable category has other ill effects. Aggressive treatments that override considerations of futility are frequently justified by standards requiring absolute certainty and by fear of malpractice. Clarifying the concept of futility and establishing defensible ethical policies covering futility are important steps toward eliminating unhelpful, medically inappropriate practices. Even the famous Baby Doe regulations of the Reagan administration, which advocated aggressive medical interventions for infants in almost all situations, recognized an exception for futility and virtual futility, when medical goals could not be achieved and quality of life had slipped below what is considered acceptably human.[18]

The Helga Wanglie case

The Helga Wanglie case did for the futility issue what the Nancy Cruzan case did for the question of medical alimentation.[19] Wanglie, an 85-year-old nursing home resident, was transferred to a hospital after suffering a heart attack. She had been re-

suscitated but remained unconscious and on a respirator. Physicians at that hospital considered continued technological life-sustaining support to be futile and wanted to withdraw it. Wanglie's husband refused and had her transferred to another medical center, where she was diagnosed as being in a persistent vegetative state. Again doctors recommended withdrawal of the ventilator because no medical goals for the patient could be realized.

The family thought the suggestion of withdrawal of life-sustaining technologies reflected moral decay in our culture and hoped instead for a miracle. Ultimately, the hospital went to court to ask whether medical professionals were obliged to provide what they considered to be unbeneficial and inappropriate treatment. The husband (a lawyer) then crossfiled, asking that he be appointed conservator. The court decided in favor of the husband's petition. More than a year after the initial hospitalization, and three days after the court decision in favor of Mr. Wanglie, Helga Wanglie died of multisystem organ failure and septicemia.

Once the Helga Wanglie case was taken to court, we could have expected that the values of the courts would inform its judgment. The judge did not address the issue of medical values or physician discretion in medical practice. Rather, he ruled that the husband was the proper surrogate and that the surrogate's claims about the patient wishes were reliable. In a culture ruled by individual rights and a purely subjective view of autonomy, the surrogate's freedom to decide about treatment held priority over physician or professional judgment about the treatment's futility.

If Helga Wanglie had actually wanted her treatment, it could be argued that she was getting some "benefit" from continuing it in the face of futility. (There is good reason to believe she did not want it.) But this kind of "benefit" is not what is meant by benefit in the history of medical ethics. Personal medical benefit consists of such advantages as restoration of health, cure, pain relief, comfort, alleviation of suffering, and improved well-being or quality of life. The principle of beneficence calls on physicians to help patients achieve those particular goals, not just any goals or any interests.

For traditional standards

Futility and physician discretion arguments will increasingly be crowded out by another influence on physician discretion—cost. The need to control medical costs will require that strict statistical measures of effectiveness be used to limit the options physicians can offer.

But independent of limitations on treatment options that might be imposed by considerations of justice and public policy, we have shown that an analysis based on beneficence allows physicians to refuse to offer—in fact, makes it their duty not to offer—futile or ineffective treatments. Futile and ineffective treatments are not acceptable or advisable even if they can be afforded.

The idea that a right exists to futile treatments is absurd, especially when there is not enough money for basic care for millions. Physicians and health care institutions need to make a stand for traditional medical rights and professional standards. ⬡

References available upon request.

"Patient autonomy, or self-determination, is first a right to refuse treatment and then a right to choose from among medically justifiable options. It is not a right to demand treatment."

Ethical Guidelines for Determining Futility

- A treatment is futile and the physician should not present it to a patient or surrogate as an option when, for example, the treatment:
  1. Does not alter a person's persistent vegetative state.
  2. Does not alter diseases or defects that make a baby's survival beyond infancy impossible.
  3. Leaves permanently unrestored a patient's neurocardiorespiratory capacity, capacity for relationship, or moral agency.
  4. Will not help free a patient from permanent dependency on total intensive care support.
- Because they require assessment of medical interventions and their relation to medical goals, decisions about futility are made by physicians, even though they involve considerations of patient benefit or patient quality of life. Some quality-of-life judgments are linked with traditional medical goals and values and assume public standards of rationality.
- Because medicine is directed to patient benefit, not everything a doctor can do falls within the ethical goals of medicine.
- Futility always involves a failure to achieve a medical goal or a personal good. If patients do not benefit in a medical sense, even temporarily effective treatments are futile and physicians have a right (indeed a duty) based on the principles of beneficence and nonmaleficence not to offer them.

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Medicine Should Reorder Its Priorities

David S. Masland, MD

Although many entities contribute to the escalating cost of health care, the author of this opinion article believes physicians have two significant alternatives when it comes to health care costs: They can continue to be a major part of the problem, or they can take the lead in rolling back the cost of medical care.

The recently published book, *Bankruptcy—1995*, predicts that the United States will be broke by 1995 unless spending in all areas is brought under control now. While the author may be in error on the year, his thesis is brilliantly defended. The national debt is rapidly approaching the point at which interest on the debt will lead to irreversible bankruptcy no matter what steps are taken.

The cost of medical care to the government is one of the major factors in this equation. Of the roughly $800 billion a year spent on medical care in the U.S., 43 percent, or roughly $350 billion, is spent directly by the government. The total amount spent on medical care is close to 12 percent of the gross domestic product. It is a figure that must be reduced if the nation is to remain solvent.

The crisis in medical care costs looms even larger because medical inflation has risen every year in recent history by double digits—even as inflation in all other areas has been at the lowest levels.

What fuels the fires of inflation under the medical care cauldron? A host of factors play a part:

- an insurance system that serves as a buffer so that patients don't know the cost of services;
- an aging population;
- an ever-increasing demand for services from a public with unrealistic expectations;
- a proliferation of high-tech, high-cost tests and procedures;
- socioeconomic factors such as poverty, illiteracy, drug and alcohol abuse, and substandard housing, to name a few; and
- a rate of increase in the cost of medications, medical supplies, and medical services far beyond the rate of increase in the overall cost of living.

Other factors include:

- the high cost of medical education;
- a proliferation of administrative activities and paperwork (some experts attribute 25 to 30 percent of medical costs to this);
- increases in premiums for malpractice insurance;
- the practice of defensive medicine; and
- the shortage of primary care physicians, especially in rural areas and inner cities.

Are physicians victims of these circumstances or perpetrators in the escalation of the cost of medical care in the U.S.? From the earliest history of medicine, physicians have acted in the best interests of their patients, self-imposing a strict code of ethics dating back to ancient Greece and expressed succinctly in the dictum, "Primum non nocere" (First of all, do no harm). As a result, most people have believed that doctors know what is best and have accepted their advice almost without question in making treatment decisions.

Traditionally in this country, community groups, working together, supplied medical care to those unable to pay for it. Physicians willingly gave their time, hospitals supplied the place, and voluntary organizations played an important role. The care provided was superb, not merely equaling but perhaps surpassing the care given to private patients. This tradition continued through the Great Depression of the 1930s. Thus, physicians experienced the sheer joy of caring for patients who would not otherwise receive medical services.

The hospital industry, the medical profession, government, and other interested organizations sought ways to assure medical and hospital care at low cost to those in society who could not afford it. Thus, nonprofit health insurance companies, Blue Cross and Blue Shield, came into ex- →

Dr. Masland, an internist who practices in Carlisle, is a past president of the State Society and past chairman of the Society's Board of Trustees. He was founding chairman of the board of the Pennsylvania Medical Society Liability Insurance Company and PMSLIC's chief executive officer from 1977 to 1989.

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istence with special enabling legislation in the various states. History shows that company-paid health insurance became a goal of organized labor, and the concept quickly spread throughout the nation's basic industries, both organized and unorganized.

Wanting a piece of the action, private insurance companies entered the competition for the premium dollar. With the advent of Medicare and Medicaid in the mid-1960s, nearly all groups in society had some form of medical care coverage.

Physicians have always earned a decent living from their work and are entitled to do so. But they differ from other purveyors of goods and services—physicians publicly promise to do that which is good for their patients. Yet, market solutions to the cost crisis in providing medical care have forced physicians to become economists.

"It is time for organized medicine...to move to cut physicians' fees for tests and procedures, and to discourage the use of unnecessary tests and procedures..."

Only a few physicians today are involved in giving care to those in need. And physician satisfaction from the practice of medicine has decreased almost in direct proportion to the onset of the application of economic standards as a measure of success. There is less joy in the physician's vocation now that success is measured in dollars.

So we have come full circle. Fees have reached an inappropriately significant level in the field of medical care. The very nature of the payment system of Blue Cross and Blue Shield led to ever-escalating costs. As premiums skyrocketed, individuals and small businesses opted out of health insurance programs. As hospital costs and physicians' fees increased, so did the cost to government as well as to individual citizens. Millions of Americans went without health insurance, and new problems developed for government programs already straining to meet the burgeoning costs.

American medical care is the best in the world—for those who have access to it. But in our heterogeneous society, and given the current crisis in insurance coverage, the outcome figures are skewed because large groups of Americans do not use the care available, and far too many do not have adequate coverage. The socioeconomic factors referred to earlier have an impact. There are serious access problems for the large pockets of black and Hispanic people living in the inner cities and for millions of other Americans without adequate coverage.

For physicians, there are two significant alternatives. On one hand, they can continue to be a major part of the problem of escalating costs—thereby contributing to a national debt that could very well lead to national ruin. On the other hand, physicians can take the lead—and it won't be easy—to roll back the cost of medical care, thereby taking one small step to secure the nation's economic health in the future.

It is time for organized medicine—physicians acting through their professional associations—to move to cut physicians' fees for tests and procedures, and to discourage the use of unnecessary tests and procedures—in short, to cut costs, because the reality is that medicine has been priced out of the marketplace for millions of people and for the government itself.

If doctors had to face patients directly with charges of thousands of dollars for procedures that take less than an hour of work, the charges would be lowered immediately. But with insurance companies acting as a buffer, charges continue to escalate.

Physicians' fees account, at most, for 20 percent of the cost of medical care. If that $160 billion each year could be cut by 10 percent, it would have a positive impact. Far greater, however, would be the moral impact when a group of respected professionals assume responsibility and take the lead in tackling this huge problem head-on. Hospitals, insurance companies, patients, the government itself, all could be expected to follow suit.

Physicians have it within their power to cut the cost of medical care by two percent. That is significant in itself, but even more significant is that the difference between survival and ruin for the nation could result when one group in society willingly bites the bullet to save the nation.

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Fighting the Access to Care Crisis

Maureen Hoepfer

Robert Doe, MD, an emergency physician at Lancaster General Hospital, has been a driving force behind an innovative coordinated care program for Medical Assistance (MA) patients that will soon be implemented in Lancaster County. The program, which was developed by a community task force comprised of physicians, hospitals, business, labor, and the insurance industry, seeks to improve access to care for MA recipients by providing them with a "medical home" and improving the coordination of their care. The Lancaster City and County Medical Society and Dr. Doe, who served as its president in 1992, played vital roles in initiating this countywide effort.

Robert Doe, MD, believes there is an access to care problem in Pennsylvania. "Our access problems have to do with inappropriate access as much as access overall. People today access care in places other than where the most logical source would be. They are going to the emergency department when they should be seeing a family physician. In my opinion, the access issue really revolves around having a medical home for each patient," he explains.

Dr. Doe contends the access to care issue is closely tied to another major problem facing the state's health care delivery system—the lack of continuity of care, especially in the Medical Assistance (MA) and uninsured patient populations. He says these patients often do not have a family physician and many times seek treatment for non-emergency conditions in hospital emergency departments at a greater cost. Also, these patients may see several different providers which may lead to a duplication of services, another costly problem for our health care system.

"Often, these patients haven't learned how, or haven't had the opportunity, to access the system in a more efficient way because they don't have a medical home," Dr. Doe explains. "As an emergency physician, I see it as the coordination problem as much as anything. How do I treat the really sick and injured when I also have to take care of a large volume of primary care cases?"

Creating a medical home

The Lancaster project began approximately two-and-a-half years ago when the Lancaster City and County Medical Society began discussing health system reform. "Figuring that health care reform was coming, it seemed logical to us to find other interest groups that shared our philosophy on the issue, align ourselves to them, and then move forward in developing our own health care reform plan," Dr. Doe says. "Initially, we formed a work group that included the business community and physicians; but we soon realized that we would have to be a lot more inclusive if we were really going to address this issue in a comprehensive manner. So we added representatives from labor, hospitals, and community agencies, as well as consumers and legislators. It eventually became a broad-based community task force."

After six months of work, the Lancaster County Task Force on Health Care, which Dr. Doe chaired, produced a document on national health system reform. According to Dr. Doe, the document contained several basic concepts:

- The medical home and primary care are important elements in improving coordination of care and access to care: Every patient needs to have a medical home.
- Administrative streamlines need to be created in whatever new system is adopted.
- The reform process should attempt to fix what is broken and not completely reject what is already working.

"At the end of this process, the task force concluded that we could help fix the health care system if we tackled something that was really broken," Dr. Doe explains. "We figured that the part of Pennsylvania's health care system that was the most broken and in the most

Ms. Hoepfer is a marketing specialist for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

need of repair was the Medical Assistance program."

Medical Assistance reform

From this realization, the task force appointed the Subgroup on Medical Assistance Reform, also with Dr. Doe as chairman. After reviewing the MA program, the subgroup determined that the system was broken for two reasons: 1) patients were accessing care in inappropriate and uncoordinated ways because they did not have a medical home to guide them in finding needed health care; and 2) the administrative side of the system was so burdensome that providers often refused to participate.

"We found a lot of physicians who actually treated Medical Assistance patients without charging them, as if they were uninsured," Dr. Doe says. "So we felt if we could make the system less administratively burdensome and expand it from the current eligibility levels to an eligibility level along the lines of 200 percent of the poverty level, then we could, first, create a more user friendly system which would encourage provider participation, and, second, solve the uninsured crisis."

From the beginning, the subgroup's goals were to realign the MA program into a coordinated health care system using the medical home as a focus of the care, to improve reimbursement for the physicians who provided the medical home, and to eliminate some of the burdensome paperwork involved. The subgroup developed a basic plan, and Dr. Doe brought it before the Pennsylvania Medical Society's Committee on Long Range Assessment in the spring of 1992. Later that year, the Society agreed to officially support the pilot project and arranged a meeting with representatives of the Pennsylvania Department of Public Welfare (DPW).

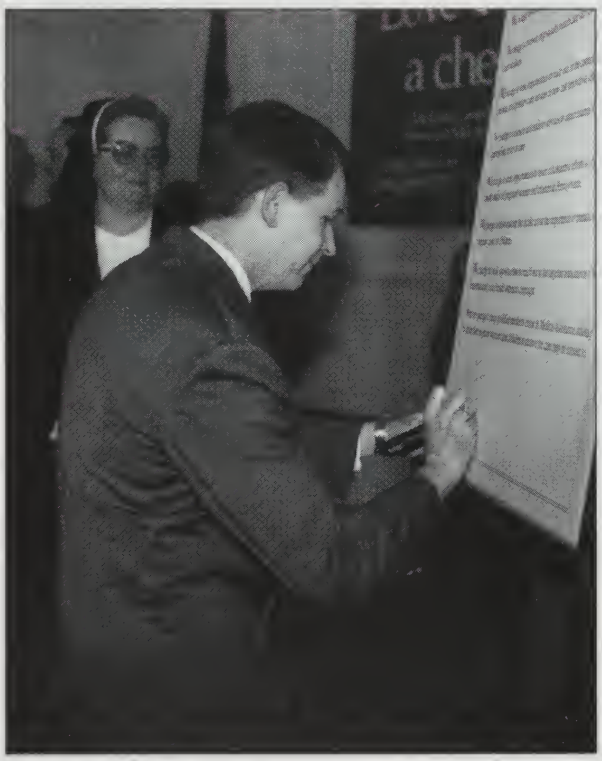
At that meeting, the Lancaster group learned there were only two avenues open for coordinated health care systems to service MA recipients through existing federal regulations—a primary care case management approach and an HMO contracting approach. "Given that we were not trying to become an insurance company, we elected to use the primary care case management approach, and through DPW applied for a waiver to the Health Care Financing Administration," he explains.

The Lancaster Task Force on Health Care is expecting approval from HCFA to move ahead with its plans by the end of this month. While waiting for the approval, Dr. Doe and the task force created two separate corporations to administer the "Lancaster Plan" and raised the appropriate start-up funds by soliciting contributions from local hospitals, physicians, insurance companies, and legislators. DPW also appropriated money through a legislative seed grant.

According to Dr. Doe, everything is in place and the two corporations—the Lancaster Community Health Plan and the Community Patient Information Network—will hopefully be in operation by late spring.

"The unique thing about this plan which comes to light as we're reaching our final goal is that we've managed to get four highly competitive hospitals and some very competitive groups of physicians to actually sit down and work together on a community project," Dr. Doe explains. "If nothing else ever comes of this project, I think the cooperation we've been able to achieve has been quite a substantial accomplishment. And, the physicians were the ones who drove it. This was a project that originally started with the county medical society, and they were able to build it into a broad-based, community partnership." ⬡

See next page for more details about the Lancaster Plan. →



Though Robert Doe, MD, is kept busy as a driving force behind the innovative Lancaster Plan, he still finds time to participate in other community projects. Above, Dr. Doe "signs on" in support of the governor's maternal and child health program.

SERVING PENNSYLVANIA'S MA POPULATION: HOW IT WORKS IN LANCASTER

The Lancaster Plan—one of three efforts in Pennsylvania to better serve the needs of Medical Assistance (MA) patients by improving access and controlling costs—is comprised of two separate corporations: the Lancaster Community Health Plan and the Community Patient Information Network. Together these corporations are expected to permit cost containment comparisons between fee-for-service coordinated care models and HMOs, and to generate health care data that will be important to the State Society and the government.

Lancaster Community Health Plan

The Lancaster Community Health Plan (LCHP) was incorporated as a nonprofit corporation in September 1993. Its function is to create a primary care case management system, which will link all participating MA recipients in the county to a primary care source of their choice.

The corporation is headed by a community-based, all-volunteer board comprised of providers, consumers, community agencies, legislators, insurers, the county assistance office, and an attorney. The board will be assisted by a salaried professional staff consisting of a chief administrator, a marketing representative, and a nurse.

Primary care providers who participate in LCHP are responsible for directing the total care of the MA patients to whom they are assigned. This includes making all non-emergency referrals to the hospitals or medical specialists when necessary, and providing access to care for their patients on a 24-hour-a-day basis. The providers will be reimbursed for services by the Pennsylvania Department of Public Welfare (DPW) at current MA rates, but will receive an additional monthly case management fee for each MA patient.

LCHP, however, offers unique features not found in other primary care case management systems. For example, the 24-hour coverage component will be supplemented by a cooperative effort between LCHP participating primary care providers (PCPs) and local emergency departments. The participating hospital emergency departments have agreed to perform a triage/gatekeeping role for interested PCPs for a fixed contractual rate. This cross-coverage system is designed to assist solo, small-group, and clinic providers in satisfying the requirement for 24-hour coverage.

Under the agreement, a registered nurse in the emergency department using a standardized software program will screen calls for PCPs that have been signed out to the emergency departments. If the patient needs to be seen by a physician, but it is not a true emergency, an emergency physician will see the patient and charge a fee equivalent to an office visit. For patients arriving in the emergency departments, similar triage advice will be given, and the patient will be offered an appointment with their PCP in lieu of an emergency visit if appropriate.

LCHP will recruit physicians and other health professionals to join the provider network, and will maintain PCP assignment files, perform quality assurance and utilization review on network providers beyond the scope of current DPW programs, respond to patient and provider complaints, and market the program to MA recipients.

Community Patient Information Network

The other unique part of the Lancaster Plan is the Community Patient Information Network (CPIN). This corporation owned by physicians, hospitals, and insurance companies in Lancaster County will create a computerized patient information network linking PCP physicians with county hospitals, medical specialists, and emergency departments.

Initially, the CPIN database will collect and maintain basic information on LCHP patients which should help reduce duplication of services, coordinate care, and allow tracking of individuals in need of care. The system will interface with DPW through the mainframe system or one of its satellite centers to receive daily updates on MA-eligible recipients in Lancaster County. In turn, DPW will be able to review PCP assignments. The CPIN system will eventually evolve to include electronic billing, a problem list for each patient, report writing for utilization profiling of providers, and the tracking of immunizations and well-child visits for individual patients.

Managed competition model

After creating the primary case management system for MA recipients, LCHP will begin negotiations with private insurance agencies to establish a private insurance option for MA recipients. Eventually, the plans will also be available to the uninsured, the underinsured, and small-group health insurance purchasers in Lancaster County.

LCHP will encourage multiple private insurers to create provider networks and offer these networks to LCHP participants. These insurers would then negotiate with DPW to receive a designated fee for each MA recipient enrolling in their insurance program. LCHP hopes to have at least three private insurers contract with DPW to ensure choice for the MA patient and competition among plans.

Once these networks are established, LCHP plans to offer its selection of the private insurance networks to others not on MA, which could include MA recipients who lose their eligibility, and other groups of uninsured and low-income workers. The insurance could be offered on a sliding scale if government funding was made available. Eventually, small employers and individual purchasers of insurance could elect to participate in the program.

Under the Lancaster Plan, LCHP will continue to exist even if 100 percent of its clients eventually select the private insurance option. LCHP's role would evolve to include:

- offering the cross coverage and CPIN network to private insurers;
- monitoring community standards by which the insurance networks could be judged;
- monitoring patient and provider complaints about the insurance networks;
- offering auxiliary services to the insurers; and
- monitoring quality assurance, utilization review, and community health data generated by CPIN.

In the end, LCHP could serve as a community watch dog monitoring the various insurance plans offered. It could assist in educating consumers in Lancaster County by comparing the insurance plans by price, provider participation, and quality outcomes.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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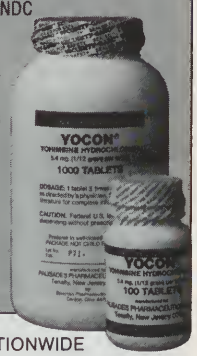

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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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RECOGNIZING HANTAVIRUS PULMONARY SYNDROME

Your patient reports fever, myalgia, and variable respiratory symptoms, including cough and headache; influenza and other respiratory illness spring to mind in your differential diagnosis. However, a new entity has now been identified which must join the list: hantavirus pulmonary syndrome (HPS). If your patient then develops the abrupt onset of acute respiratory distress and no other pathogen is likely, HPS should be considered.

First recognized in the southwestern U.S. in May 1993, HPS has been confirmed in 42 persons reported to the Centers for Disease Control and Prevention (CDC) from 12 states as of October 21, 1993. As of yet, no cases have been identified east of the Mississippi. Ages have ranged from 12 to 69 years; 22 were male, and overall, 26 have died. Bilateral pulmonary infiltrates developed within two days of hospitalization, and the hospital course was characterized by fever, hypoxia, and hypotension.

Recovery in survivors has been without sequelae. Pathologically, the hallmark of the disease is the capillary-leak syndrome, with flooding of the alveoli by plasma. Hantavirus antigens can be detected by immunohistochemistry in formalin-fixed tissues and have been detected primarily in the endothelial cells in most organs, with marked accumulations in the lungs. Serology and polymerase chain reaction testing are also used for serum and tissue specimens, respectively.

Unlike previous hantavirus infections in other countries, which have been characterized by hemorrhagic features and renal involvement, hantavirus infection in the U.S. is characterized more typically by respiratory symptoms and only limited renal involvement. However, as of this writing, no defined set of symptoms and signs reliably distinguishes HPS at the time of presentation from other forms of noncardiogenic pulmonary edema or adult respiratory distress syndrome. The prognosis is poorest in patients with shock, and supportive measures are the basis for therapy. Testing for alternative diagnoses should be done.

To standardize the investigation of persons with possible HPS, the CDC and the Council of State and Territorial Epidemiologists (CSTE) have published clinical screening criteria to detect persons with an illness similar to those with confirmed hantavirus infection (see box, below). A packet containing the following is available:

- a copy of the October 29, 1993, *MMWR* article, "Update: Hantavirus Pulmonary Syndrome—United States, 1993";
- screening criteria;
- case report form, and
- laboratory specimen form.

To receive this packet or more information, contact your local state health center; your county/municipal health department; or the Division of Communicable Disease Epidemiology, Pennsylvania Department of Health, P.O. Box 90, Room 1014, Harrisburg, PA 17108, (717) 787-3350.

Maria Moll, MD
Pennsylvania Department of Health

Screening Criteria for HPS in Persons with Unexplained Respiratory Illness

Potential case-patients must have one of the following:

- a febrile illness (temperature ≥101°F [≥38.3°c]) occurring in a previously healthy person, characterized by unexplained adult respiratory distress syndrome, or bilateral interstitial pulmonary infiltrates developing within one week of hospitalization with respiratory compromise requiring supplemental oxygen; or
- an unexplained respiratory illness resulting in death, in conjunction with an autopsy examination demonstrating noncardiogenic pulmonary edema without an identifiable specific cause of death.

Potential case-patients are to be excluded if they have any of the following:

- a predisposing underlying medical condition (e.g., severe underlying pulmonary disease; solid tumors or hematologic malignancies; congenital or acquired immunodeficiency disorders; or medical conditions such as rheumatoid arthritis or organ transplant recipients, requiring immunosuppressive drug therapy such as steroids or cytotoxic chemotherapy); or
- an acute illness that provides a likely explanation for the respiratory illness (e.g., recent major trauma, burn, or surgery; recent seizures or history of aspiration; bacterial sepsis; or another respiratory disorder such as respiratory syncytial virus in young children, influenza, or legionella pneumonia).

Confirmed case-patients must have the following:

- at least one specimen (serum and/or tissue) available for laboratory testing for evidence of hantavirus infection, and
- in a patient with compatible clinical illness, either serology (presence of hantavirus-specific immunoglobulin M or rising titers of immunoglobulin G), polymerase chain reaction for hantavirus RNA, or immunohistochemistry for hantavirus antigen is positive.

Source: MMWR, *October 28, 1993, pp. 816-820.*

STATEMENT ISSUED ON SCREENINGS FOR ASYMPTOMATIC PATIENTS

The Society's Commission on Licensure and Practice of the Health Care Professions has issued the following statement for Pennsylvania physicians:

According to information received from Berks County by the Society's Commission on Licensure and Practice of the Health Care Professions, a Florida-based company called Ultra-Life has been conducting carotid ultrasound and echocardiography scans on presumably asymptomatic members of local realty associations. The company's flyer claims that heart attacks and strokes can be prevented by its Test 1—Carotid Ultrasound Scan and Carotid Doppler Blood Flow Analysis, and Test 2—Heart Echocardiography and Heart M-Mode, at a total cost of $150. The flyer also claims the series would cost between $800-1,200 if done in a hospital. Test results are reportedly prepared by a "board certified (MD) specialist."

The commission believes that such routine testing does not represent acceptable medical practice and is a waste of scarce health care resources. However, after extensive investigation of the issue, it determined that an attempt at action against the

company would be futile. Nonetheless, the commission believes the medical profession should be aware of these activities.

Direct any questions to the Society's Department of Educational and Scientific Affairs at (800) 228-7823 or (717) 558-7750.

Robert J. Lilley, the Society's assistant director of educational and scientific affairs, contributed to the above article.

NICOTINE DEPENDENCY TEST OFFERED FOR SMOKERS

Physicians at the University of Pittsburgh Medical Center's (UPMC's) Comprehensive Lung Center have a simple written nicotine dependency test for smokers who have been thinking about quitting.

Heavy smokers often begin to experience physical withdrawal symptoms within two hours of giving up cigarettes. Symptoms may include restlessness, irritability, and frustration. "Nicotine replacement is aimed at minimizing these symptoms," according to Gregory Owens, MD. "This must be combined with stress reduction, behavioral modification, physical monitoring, and most importantly, follow-up, if a smoker is to successfully quit." He adds, "Smoking cessation must be geared toward treating the whole person, not just the smoking habit."

Scores of seven or more on the nicotine dependency test (at right) indicate that a smoker is highly dependent on nicotine and may need nicotine replacement to stop smoking. Scores of six or less indicate that a smoker has a low to moderate nicotine dependency and may not need nicotine replacement to quit smoking.

For more information, call UPMC's Comprehensive Lung Center at (412) 648-6161.

Nicotine Dependency Test*

This test measures physical nicotine dependence.
After answering all the questions, total your score, and refer to the article (at left).

Points	0	1	2	Score
1. How soon after you wake up do you smoke your first cigarette?	After 30 min.	Within 30 min.		
2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as a library, theater, or doctor's office?	No	Yes		
3. Of all the cigarettes you smoke in a day, which is the most satisfying?	Any other than the first one in the morning	The first one in the morning		
4. How many cigarettes a day do you smoke?	1 to 15	16 to 25	26 or more	
5. Do you smoke more during the morning than during the rest of the day?	No	Yes		
6. Do you smoke even when you are so ill that you are in bed most of the day?	No	Yes		
7. Does the brand you smoke have a low, medium, or high nicotine content?	Low 0.4 mg or less	Medium 0.5 to 0.9 mg	High 1.0 mg or more	
8. How often do you inhale the smoke from your cigarette?	Never	Sometimes	Always	
How motivated are you?				
1. When you make up your mind to do something, do you follow through on it?	Most of the time	Some of the time	Usually not	
2. Do you find that getting help from family, friends, or professionals has helped you achieve desired goals?	Yes	No		
			Total Score	

**Adapted from the Swedish scientist Karl Fagerstrom*

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AMA House Meeting Draws National Media Attention

The AMA House of Delegates Interim Meeting, held December 5-8, 1993, in New Orleans, received extensive media coverage nationwide when delegates voted to soften their support for an employer mandate as part of U.S. health system reform.

One newspaper reported that the AMA "dropped its support for the employer-mandate proposal," and another said the organization "move[d] against the employer mandate." But that wasn't the case, according to Delegation Chair Howard A. Richter, MD.

"The AMA House didn't eliminate the possibility of an employer mandate," Dr. Richter says. "All it did was make sure our options remain pluralistic...The whole point of reform is to assure universal coverage, [and] *if* there is an alternative to an employer mandate, we'd like it to be considered."

AMA Board Chair Lonnie R. Bristow, MD, further explained that the House action was "aimed at expanding the range of options for achieving universal coverage," and included "both employer and employee funding options."

The House action directs the AMA to "oppose any proposed legislation mandating that employers be totally responsible for employees' insurance premium costs." Dr. Richter says the media reports were a result of "misinterpretation" of the action.

Three state resolutions adopted

Amidst all the media attention, the AMA House considered a number of other resolutions, including 10 from the Pennsylvania Delegation. Of those, three resolves were adopted, directing the AMA to:

- ask the Health Care Financing Administration (HCFA) to require Medicare carriers to be responsible for repayment of any overpayments where physicians could not have been reasonably aware of an error;
- develop policies to recognize internists, pediatricians, family practitioners, and obstetricians/gynecologists as capable of providing both primary and consultative care; and
- adopt the policy that medical staff bylaws not allow proxy voting prior to a medical staff meeting.

Dr. Richter reports that several Pennsylvania resolutions were not adopted because they were not popular. Among those were three asking the AMA to: restudy dread disease insurance as part of health system reform; establish a committee on alternative health methods to gather, interpret, and disseminate accurate information on alternative medicine; and encourage *JAMA* to publish data from a Pennsylvania physician survey of cult activity, or conduct its own survey of AMA members.

About the outcomes of the unpopular resolutions, Dr. Richter says, "That happens. We shouldn't

Delegation Election Results

The Pennsylvania Delegation to the AMA conducted its biennial elections for the contested positions in the delegation during the interim meeting of the AMA House of Delegates in New Orleans in December. **Howard A. Richter, MD,** Delaware County, was re-elected chair; **Donald C. Brown, MD,** Westmoreland County, was newly elected vice chair; **Michael J. Prendergast, MD,** York County, was re-elected secretary; **Victor F. Greco, MD,** Luzerne County, was re-elected delegate-at-large; and **Richard T. Bell, MD,** Berks County, was newly elected delegate-at-large.

SPRING ASSEMBLY TO FOCUS SHARPLY ON HEALTH REFORM

Determining a focus for the Society's annual spring educational gathering came quickly to the committee, according to Chair John W. Mills, MD. He says it was clear, even early last year when the committee first began discussions, that joining specialists, other health practitioners, and all the various providers together to preserve essential aspects of medicine would be vital in 1994.

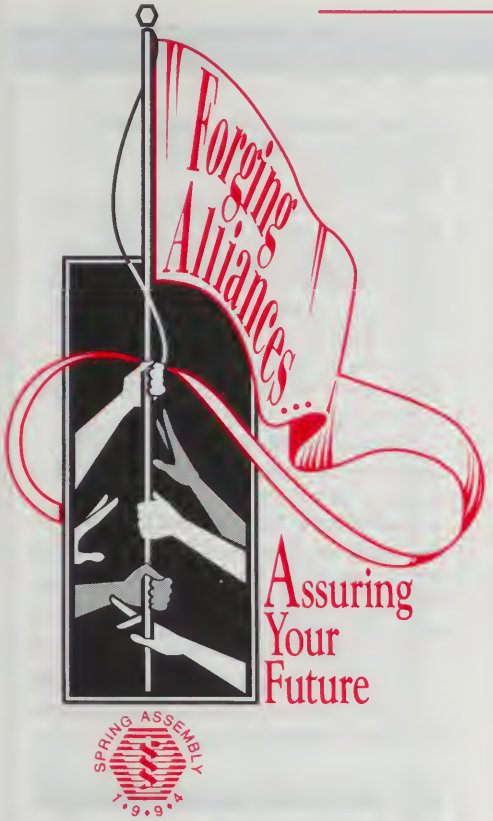
This year's theme, "Forging Alliances...Assuring Your Future," is the natural outgrowth of this realization. The committee hopes to convey the enormous potential for alliances among medicine's factions, and has designed a program to help build members' political and negotiating skills. The Spring Assembly (formerly Leadership Conference) will be held noon to noon, April 19-20, 1994, at the Harrisburg Hilton and Towers.

Richard F. Corlin, MD, a California physician and member of the AMA Board of Trustees, will open the first day of the meeting with a keynote address on the future of medicine. Other nationally known speakers—including a high-ranking Clinton administration official—will discuss such pertinent issues as the future of health system reform and how to deal with it, and alliances with other health care professionals.

Day two will begin with the President's Address by State Society President Martin A. Murcek, MD, followed by presentation of the Society's first-ever Physician Volunteer Award. The award is the result of a 1991 House action directing the Society "to honor on a yearly basis an outstanding Society member distinguished for volunteer community service." PENNSYLVANIA MEDICINE will profile this year's recipient in conjunction with follow-up coverage of Spring Assembly.

Also on day two, six workshops will be offered on topics including: personal computers, organizational options for medical staff in the changing health care environment, personal financial planning for physicians, managed care contracts, effective approaches to legislators and the public, and bioethics.

Registration forms for the assembly were published in this month's *Executive Report.* For additional information, see opposite page. Also, final details about Spring Assembly will be featured in the *Newsfronts* section of PENNSYLVANIA MEDICINE next month.



Pennsylvania Medical Society

Spring Assembly April 19-20, 1994

Harrisburg Hilton and Towers

Keynote Address:

"What is the Future?"—Richard F. Corlin, MD, immediate past president of the California Medical Association and member of the AMA Board of Trustees. Dr. Corlin was a featured speaker at the Forum on Health System Reform that opened the 1992 annual meeting of the Society's House of Delegates in Philadelphia.

Plenary Speakers:

"What is the Future of Health System Reform?"—A high-ranking Clinton Administration official —promised by the Democratic National Committee— will address the future as seen by the White House.

"Dealing with the Future."—Jennifer James, PhD, cultural anthropologist, lecturer, and columnist for *The Seattle Times,* will discuss the ways in which we confront and respond to change.

"Alliances with Health Care Professionals"—Thomas M. Reardon, Esq., of Mintz, Levin in Boston, returns after scoring one of the most popular presentations of last year's conference. He will bring to the assembly his extensive experience in forming physician groups.

Six Workshops—Tools for Building Alliances:

"Computers Made Easy"—A discussion of the basics of personal computers and the growing role PCs are playing in the health care system, presented by Edward H. Dench Jr., MD, member of the Society's Board of Trustees, and Dr. Dench the Society's representative on the state's HealthNet Task Force to develop a pilot telemedicine program for Pennsylvania.

"PHO . . . Friend or Foe?"—Developed in cooperation with the Hospital Medical Staff Section Governing Council and presented by Jill Willen of KPMG Peat Marwick, this workshop will explore the benefits of developing physician alliances in the turbulent times of system reform.

"Financial Planning in the Changing Environment"—Presented by AMA Investment Advisors, Inc., and developed with the Young Physician Section Governing Council,. this workshop will include repayment of educational debts, buying a house, buying insurance, establishing an investment plan, and saving for retirement.

"Contracting with Managed Care Organizations"—Presented by popular past speaker, Alice G. Gosfield, Esq., a health care law specialist from Philadelphia, this presentation is a must for physicians confronted with tough choices in the business side of medicine.

"Difficult Decisions for Patients and Families"—A discussion of the ethical considerations presented by health system reform, led by Stuart Youngner, MD, associate professor of medicine, Department of Psychiatry and Biomedical Ethics, Case Western Reserve University School of Medicine, Cleveland, Ohio.

"Winning Approaches to Your Legislator and the Public"—Presented by Robert Lamb of The Educational and Scientific Trust and Amy Dugan, media relations director for the Society. Be effective in your contacts with local governmental officials and the public on issues important to your practice.

Look for Spring Assembly registration information in the February issue of *Executive Report*

Also . . . Don't miss the
20th HMSS Assembly
"Forming PHOs: Hospital and Physician Perspectives"
Tuesday, April 19 • 8:30 - 11:30 a.m.
Come to the Hospital Medical Staff Section Assembly and stay for the Spring Assembly!
For HMSS information, contact Stacy Wenger at the Pennsylvania Medical Society,
(800) 228-7823.

worry." He adds, "The delegation performed admirably in all of its deliberations, and we are functioning extremely well at this time."

TWO SEMINARS SCHEDULED PRIOR TO SPRING ASSEMBLY

Among several events scheduled in conjunction with the Society's 1994 Spring Assembly are two semiars addressing political and Hospital Medical Staff Section (HMSS) issues.

Practicing politics

At "Practicing Politics," a full-day seminar scheduled April 18 at the Harrisburg Hilton, nationally recognized speaker Michael Dunn will present "political skills you need to have an impact on the 1994 election."

Sponsored by the American Medical Political Action Committee (AMPAC) and the Pennsylvania Medical Political Action Committee (PAMPAC), the seminar will include a legislative issues briefing and personal visits with state legislators at the Capitol.

The seminar is open to all State Society and Alliance members. A small fee is being charged to cover the cost of lunch. For more information or to register, call the PAMPAC office at (717) 558-7822 or the State Society at (800) 228-7823.

Improving clinical decision making

How do physicians and hospital medical staffs remain competitive in an era of downsizing, managed care, and prospective reimbursement? How can they demonstrate quality results and still keep their practices and hospital lean, yet retain the rewards of improved efficiency? Those are the questions the new, half-day seminar, "Improving Cost-Effective Clinical Decision Making," will answer the evening before the Society's Spring Assembly.

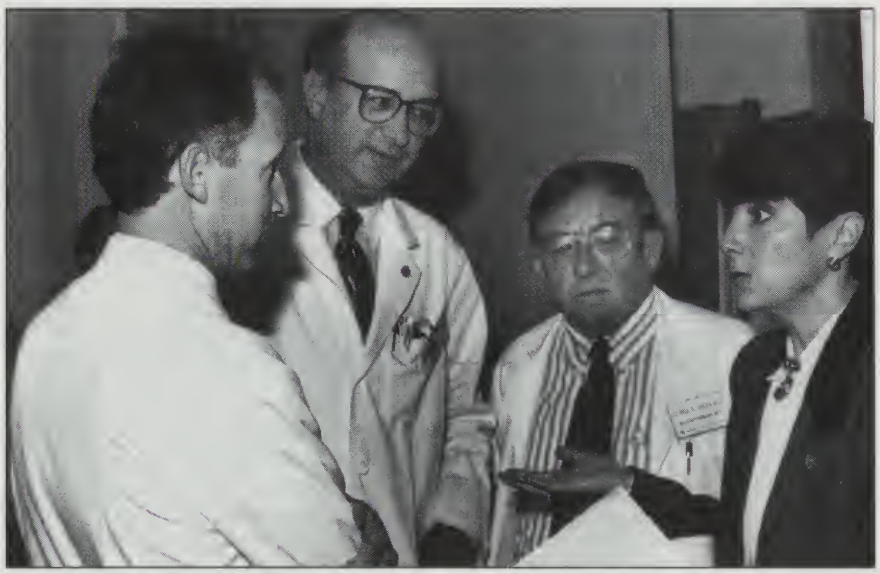
Hospital medical staff leaders—including physicians directing quality assurance, utilization review, risk management, and cost containment—are invited to attend this train-the-trainer experience in which participants will receive materials and skills to help them train their own medical staffs in the most efficient use of hospital resources. Speakers will include:

- Toni M. Casale, DO, director of outcomes and assessment, Philadelphia College of Osteopathic Medicine, Philadelphia;
- Lee H. McCormick, MD, chairman, of the AMA-HMSS;
- David B. Nash, MD, MBA, director of health policy and clinical outcomes, Jefferson Medical College, Philadelphia; and
- David J. Shulkin, MD, director of clinical outcomes assessment and quality management, University of Pennsylvania Medical Center, Philadelphia.

The seminar, cosponsored by the Society's Hospital Medical Staff Section (HMSS) and The Scientific and Educational Trust's Institute for Physician Leadership, begins at 4:00 p.m. on April 18 at the Harrisburg Hilton and concludes at 8:00 p.m. Four hours of Category 1 CME credit have been requested.

The cost of the seminar, which includes the evening meal, is $130 for Society members and $165 for nonmembers. Medical staffs and hospitals are eligible for group discounts when more than one physician attends from the same hospital or health care organization.

For further information, call (800) 228-7823, extension 461. Registration deadline is March 31.



More than 40 physicians attended the November meeting of the Montgomery County Medical Society (MCMS), held at Abington Memorial Hospital and featuring U.S. Representative Marjorie Margolies-Mezvinsky (right). According to MCMS Executive Director U. Berkley Ellis, EdD, "The physicians and the congresswoman had a profitable, positive dialogue." Pictured with Representative Margolies-Mezvinsky are (from left): Arthur M. Frankel, MD, president of Abington's medical staff; David J. Eskin, MD, chief of staff; and George R. Green, MD, MCMS president.

COUNTY NEWS

DR. MCCORMICK INAUGURATED 129TH ACMS PRESIDENT

Lee H. McCormick, MD, was inaugurated as the 129th president of the Allegheny County Medical Society (ACMS) at the annual installation of officers on January 8, 1994. He succeeds George J. Gerneth, MD.

Dr. McCormick is a family practitioner affiliated with Jefferson Hospital and Braddock Medical Center. Certified by the American Society of Addiction Medicine, he also serves as medical director of drug and alcohol recovery services at both institutions. A graduate of the University of Pittsburgh School of Medicine, he served his internship at South Side Hospital and residency at Montefiore Hospital.

Dr. McCormick has been an active member of organized medicine since 1959. Currently, he is Hospital Medical Staff Section (HMSS) representative on the State Society's board, as well as a member of the Physicians' Health Programs Advisory Committee and the Pennsylvania Delegation to the AMA. He also is a board member of the Foundation for a Drug Free Pennsylvania.

Other ACMS officers installed were: Nancy S. Nieland, MD, a dermatologist affiliated with

Need more information about member resources?

With this issue of PENNSYLVANIA MEDICINE you received a "Resource Guide" of services, products, officials, and contacts available to members of the Pennsylvania Medical Society. For more information about any State Society service, call:

1-800-228-7823

Mark your calendar for

THE SECOND ANNUAL ONCOLOGY SEMINAR: ADVANCES IN CURRENT THERAPY

Thursday, March 24, 1994
Shadyside Hospital, Pittsburgh, PA

Dennis J. Meisner, M.D.
Course Director

PRESENTERS AND TOPICS INCLUDE:

- **Martin D. Abeloff, M.D.**, Johns Hopkins Oncology Center, Baltimore, MD
  Treatment of Early Stage Breast Cancer
- **Ms. Helene Brown**, Johnsson Comprehensive Cancer Center, Los Angeles, CA and **B.J. Kennedy, M.D.**, University of Minnesota Hospital & Clinic, Minneapolis, MN
  Alternative Cancer Treatments: Cancer Quackery vs. Hopeful Beginnings
- **Lawrence H. Einhorn, M.D.**, Indiana University Medical Center, Indianapolis, IN
  Treatment Update in Small Cell Lung Carcinoma
  Advances in Testicular Cancer Therapy
- **Alan Saven, M.D.**, Scripps Clinic and Research Foundation, La Jolla, CA
  Development of 2-CDA and Its Use in Low-Grade Lymphomas
- **Charles Schiffer, M.D.**, University of Maryland Cancer Center, Baltimore, MD
  Advances in Acute Myeloid Leukemia

Shadyside Hospital is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

An application has been submitted to the Oncology Nursing Society for 5.5 contact hours of continuing education for R.N.s attending the Shadyside Hospital Second Annual Oncology Seminar: Advances in Current Therapy. The Oncology Nursing Society is accredited as an approver of continuing education by the American Nurses Credentialing Center's Commission on Accreditation.

Shadyside Hospital designates this continuing medical educaiton activity for 5.5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

For registration information, please contact the Department of Continuing Medical Education at (412) 623-2393, or Fax 623-3010.

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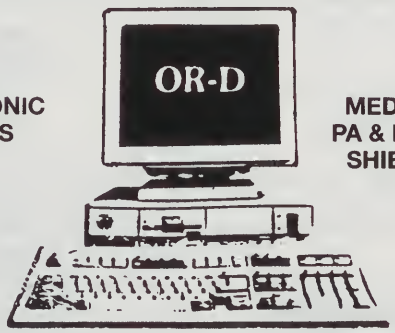

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Presbyterian-University, Children's, Montefiore, St. Margaret, and St. Francis hospitals, as president elect; Richard N. Harris, MD, an internal medicine specialist affiliated with Presbyterian-University, Eye and Ear Institute Pavilion, and Shadyside hospitals, and St. Francis Medical Center, as vice president; and Alan A. Axelson, MD, a psychiatrist with an emphasis on children and adolescents, as secretary. John S. Oehrle, MD, a pathologist, will serve a sixth term as ACMS treasurer.

MERCER COUNTY PHYSICIANS DISCUSS REFORM

Nino Camardese, MD, immediate past president of the Association of American Physicians and Surgeons, shared his philosophical views on health system reform at the November meeting of the Mercer County Medical Society.

Though Dr. Camardese did not argue specific proposals of President Clinton's health plan, he did say that people only have to look at history to discover that the plan is one that should not have to be put into practice. He said the plan is a form of government oppression which takes choice away from physicians and their patients and gives it to government.

Instead of the proposed National Health Care Advisory Board and its state alliances, Dr. Camardese suggested a medical savings account program—patients would pay for their own minor medical expenses, and regular deposits to a special account would be used to pay for major illnesses and injuries. He said, "If we empower the individual with responsibility, then we literally allow the individual to maintain dignity and pride."

Physicians interviewed by *The (Youngstown) Vindicator* said the following about President Clinton's proposed health system reform:

- It is at the very least a socialistic agenda.
- It will thwart competition and result in substandard care.
- It is overbearing.
- The country's Veterans Administration hospitals are examples of what would happen if the Clinton plan was enacted.

Approximately 75 physicians and spouses attended the monthly meeting, held at Grove City Country Club.

ORTHOPEDIC SOCIETY PLANS SPRING MEETING

The Pennsylvania Orthopedic Society will hold its Spring 1994 meeting, "Total Knee Arthoplasty: Advances, Complications, and Outcomes," April 20-23 at the Boca Raton Resort and Club, Boca Raton, Florida. The meeting offers 12.5 hours of Category I CME credit.

For more details about the meeting, or to register, call (800) 228-7823 or (717) 558-7750, extension 447.

PHILADELPHIA INSTITUTIONS LINK TO PRESERVE STRENGTHS

Pennsylvania Hospital and Thomas Jefferson University, both in Philadelphia, have agreed to formally link their academic, clinical, and administrative programs to preserve and build on the strengths of both institutions.

By developing formal relationships, the hospital and university hope to strengthen the quality of undergraduate and graduate medical education programs, enhance faculty development, coordinate continuing medical education, enhance cooperation in clinical programs, and expand the network of services offered to the communities they serve. Ultimately, they will share common clinical leadership. The governing bodies of both institutions have approved "guiding principles" for the agreement.

As part of their long-term evolutionary commitment, Jefferson and Pennsylvania Hospital will build on existing agreements in orthopedics and otolaryngology-head and neck surgery, where the chairmen of these departments serve in key leadership roles at both institutions. This commitment will expand to other departments in the future.

GEISINGER CLINIC

1993-1994 Continuing Education Programs

12th Annual Winter CME Festival
February 16-19, 1994
Stouffer Hotel, Valley Forge

Advanced Cardiac Life Support Renewal Course
Wednesday
February 16, 1994 OR
Wednesday
May 18, 1994

Contemporary Issues in Internal Medicine
Wednesday
March 2, 1994

Advanced Cardiac Life Support Provider Course
March 4-6, 1994

Advances in Dermatology
Wednesday
April 6, 1994

Annual Rheumatology Seminar
Wednesday
April 13, 1994

Annual Thoracic Medicine Seminar
Wednesday
April 20, 1994

Annual Mental Health Seminar
Friday
April 22, 1994

8th Annual Sight Loss Support Group Meeting
Wednesday
May 4, 1994
Danville Days Inn

Cutaneous Surgery
Monday & Tuesday
May 16 & 17, 1994

Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

717-271-6692 or 1-800-272-6692

Geisinger

As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, Geisinger designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, at 1-800-272-6692. There is a 24-hour answering service available. You may also write to her at 100 North Academy Avenue, Danville, PA 17822-1350.

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David M. Capuzzi MD, Medical College of Pennsylvania	Hyperlipidemia
Sheldon Goldberg MD, Thomas Jefferson University	Coronary Stenting
Scott M. Goldman MD, Thomas Jefferson University	Coronary Artery Bypass
Manoj Khandelwal MD, Hahnemann University	Valve Repair or Replacement
Donna M. Mancini MD, Columbia University	Congestive Heart Failure
Roger A. Marinchak MD, Thomas Jefferson University	Pacemaker Therapy
Judith H. Murphy MD, Hahnemann University	Stunning and Hibernation
Eric N. Prystowsky MD, Duke University	Nonsustained VT
Melvin M. Scheinmann MD, University of California	Supraventricular Tachycardia
Francis J. Uricchio MD, Hahnemann University	Platelets and CAD
Michael A. Weber MD, University of California, Irvine	Ambulatory BP Monitoring

Course Directors: Francis J. Uricchio MD and Peter R. Kowey MD

Sunday, May 1, 1994
Main Auditorium
The Lankenau Hospital and Research Center
100 West Lancaster Avenue
Wynnewood, PA 19096

for information, contact
Ms. Roe Wells, Lankenau Cardiology Foundation (215) 645-2682
Registration $50, CME Credits available through The Lankenau Hospital

HCQII: Sources of Cooperative Projects

Donald E. Harrop, MD

This is a continuation of a review of some of the various components of the Keystone Peer Review Organization's (KePRO's) Health Care Quality Improvement Initiative (HCQII). Last month's article dealt mainly with focused medical review and briefly referred to cooperative projects which are really the basis of the HCQII. Future articles will address the two kinds of cooperative projects, local and national. Here we will look at the major sources of cooperative projects and more of the HCQII process.

To begin, I should state that cooperative projects are appropriately named—that is, they must rely upon the coordinated involvement of a number of participants. Hospital medical staffs, administration, and the individual members of each; study groups, and committee members; as well as Keystone Peer Review Organization (KePRO) staff, must all cooperate and be committed to a project in order to assure its success.

Identification of subjects for cooperative projects can come from a variety of sources. These may include specialty societies whose members may recognize variations from physician to physician in the way certain diagnoses are managed, procedures are performed, or in outcomes of care. Subjects may also result from published literature review or data analysis, or they may be identified by our Steering Committee, clinical coordinators or staff epidemiologist, or even members of the public such as Medicare beneficiaries.

Of course, the most knowledgeable and reliable sources of projects are the specialty societies, individual physicians, and providers. Because of this, a little more is expected of members of these groups when one of them suggests a project. We would expect that a clinical hypothesis be established, backed by a literature search prior to assignment to our pattern analysis staff. This expedites the project development cycle and allows our clinical coordinators and pattern analysis staff to more easily develop proposals for the Project Development Committee. Individual physicians who wish to suggest a cooperative project subject, please see the box below.

Data are another excellent source of potential projects. The quarterly MEDPRO reports, Medicare hospital claims data, KePRO review data, Health Care Financing Administration (HCFA) national data, and PRO data from other states are used by our pattern analysis staff to conduct data analysis. Staff attempts to identify patterns from the Pennsylvania data which may form the basis for cooperative projects.

Although Medicare beneficiaries have limited knowledge of health care delivery or potential clinical issues, they are another source of projects. They bring to the process the consumer's perspective on what constitutes quality of care and often identify important matters which providers may overlook at a particular level.

There are a variety of ways in which we receive beneficiary input, including the beneficiary hotline and complaint letters. Subjects which have potential as cooperative projects are referred to the Health Care Improvement Department to determine if a clinical hypothesis can be developed, and if so, the pattern analysis staff examines the data to see if any variations exist.

As cooperative projects are completed, outcomes are measured to determine if there have been improvements in patient care.

Within the next few months, we hope to complete our first few projects. The most interesting part of this whole process will be seeing whether or not we have been able to have a positive effect on medical practice.

Physicians who wish to suggest a cooperative project subject should call the KePRO Communications Department at (717) 564-8288 and request an "Improvement Project Suggestion" form.

Dr. Harrop is president of the Keystone Peer Review Organization.

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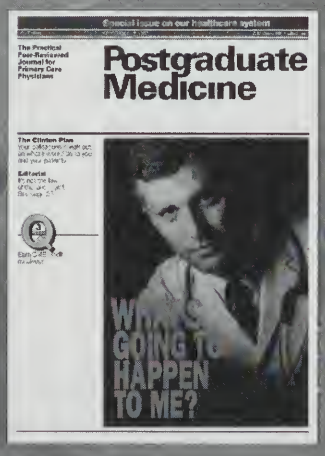

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MEDICARE PAYMENT POLICY CHANGES OVERVIEWED

This is a summary of various Medicare payment policy changes that became effective for service dates on or after January 1, 1994. Physicians are advised to take note of these changes since they will affect billing and subsequent reimbursement from Medicare.

Anesthesia services furnished by non-anesthesiologists

Under the fee schedule, separate payment is not allowed for an anesthesia service that a surgeon may perform in addition to and concurrent with a surgical procedure. In the past, however, the Medicare carrier—Pennsylvania Blue Shield—has allowed a psychiatrist who furnishes electroconvulsive therapy and the associated anesthesia service to be paid separately for the anesthesia service.

Separate payment will no longer be allowed. Relative value units (RVUs) for CPT Code 90870 (electroconvulsive therapy) have been increased to include payment for the anesthesia.

Site-of-service payment differential

In the past, payment for services routinely furnished in physicians' offices was reduced when such services were furnished in hospital outpatient settings (places of service 22, 23, and 62). Application of this site-of-service differential is being extended to include hospital inpatient settings. Also, the differential will now be applied to office and confirmatory consultations. Practice expense RVUs for these consultations have been reviewed so that they are based on office charge data only.

Payment for supplies other than drugs

Urological Procedures (Cystoscopies): In the past, Blue Shield allowed separate payment for a surgical tray under HCPCS Code A4550 for certain procedures when performed in a physician's office. Twenty-one cystoscopy codes have been added to the list of services for which the carrier allows a separate payment for supplies.

Catheters: Separate payment will now be made for catheters used by physicians in the treatment of temporary obstructions when performed in a physician's office. HCPCS Code G0002 (office procedure, insertion of temporary indwelling catheter, Foley type [separate procedure]) has been created for this purpose. This code will only be paid for when performed in the physician's office. Blue Shield will not pay for Code G0002 when it is performed on the same day as or during the post-operative period of a major surgical procedure.

Unna Boots: The Bureau of Policy Development has added 0.5 RVUs to the practice expense of CPT Code 29580 (strapping; unna boot) to account for additional supply cost incurred when this procedure is performed in an office setting. The additional RVUs have been subtracted in the calculation of the payment amount for the site-of-service differential. This reduction is already reflected in the Medicare Fee Schedule Data Base (MFSDB). Since this procedure is virtually always performed in the office, the carrier is not installing additional edits.

Lacrimal Punctum Plugs: Blue Shield will allow separate payment for silicone punctal plugs when the new HCPCS Code A4263 (permanent, long term, non-dissolvable lacrimal duct implant, each) is reported with CPT Code 68761 and an office place of service is used.

Implantable Vascular Access Devices: HCPCS Code A4300 (implantable vascular access device) is listed with a status code of "X" (excluded from the physician fee schedule) on the MFSDB. Since these devices are supplies incident to a physician's service (CPT Code 36533—insertion of implantable venous access port, with or without subcutaneous reservoir), the "X" status code is incorrect. The status code has been changed to an "A," and separate payment will be allowed when Code A4300 is billed with Code 36533.

E/M services

Prolonged Evaluation and Management (E/M) Services: Medicare will pay for the prolonged services CPT Codes 99354 (prolonged physician service in the office or other outpatient setting, first hour); 99355 (prolonged physician service in the office or other outpatient setting, each additional 30 minutes); 99356 (prolonged physician service in the inpatient setting, first hour); and 99357 (prolonged physician service in the inpatient setting, each additional 30 minutes) when the following criteria are met:

- The physician has furnished and billed one of the following CPT codes for the patient on the same day: *in the case of 99354:* 99201 through 99205, 99212 through 99215, 99241 through 99245; *in the case of 99355:* 99354 **plus** one of the codes required for 99354 to be used; *in the case of 99356:* 99221 through 99223, 99231 through 99233, 99251 through 99255, 99261 through 99263, 99301 through 99303, 99311 through 99313; and *in the case of 99357:* 99356 **plus** one of the codes required for 99356 to be used.
- The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the *physician* and the patient (whether or not the service was continuous).
- The medical record documents the content of the E/M service code billed, and the duration and content of prolonged services that the physician personally furnished after the typical time of the E/M service has been exceeded by at least 30 minutes. Documentation need not be submitted to the carrier for processing purposes.

Ventilator Management on the Same Day as an E/M Service: Ventilation management codes (CPT Codes 94656, 94657, 94660, and 94662) will continue to be payable services under the physician fee schedule. However, payment will no longer be made for ventilation management when an E/M code is billed on the same day; ventilation management is considered bundled into the E/M codes. There will no longer be a global period associated with ventilation management, so CPT modifier -25 will no longer be accepted to justify payment for an E/M service provided on the same day as ventilation management.

Clinical interpretation services

Medicare has recognized 15 clinical laboratory tests for which a clinical laboratory interpretation fee could be recognized if the test is furnished by a laboratory physician. Four codes (84181, 84182, 88371, and 88372) have been added to the list for payment.

Questions?
Call the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

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Workers' Compensation Laws Undergo Significant Change

The Health Care Group

More than six months have passed since Act 44, the Pennsylvania Workers' Compensation Act, was signed into law. The act imposes additional requirements and prohibitions to the state's already complicated workers' compensation system—changes such as revisions to the reimbursement rates and fee schedule review process, self-referral prohibitions, and alterations to the utilization review and peer review process. Since these new tenets continue to affect physicians as both health care providers and employers, they are briefly reviewed here for members' reference.

Reimbursement schedule, fee review

The act generally caps medical fees at 113 percent of the applicable Medicare reimbursement rate or of the diagnostic-related group (DRG) payment, plus pass-through costs. If Medicare employs any other reimbursement mechanism, the fee is capped at 113 percent of the reimbursement determined by the Medicare carrier or intermediary. This cap on fees applies to all health care providers treating injured employees, regardless of whether the provider participates in the Medicare system. If Medicare has not established a fee for a particular treatment or service, then payment may not exceed 80 percent of the usual and customary charge.

All bills for medical services must be submitted on a HCFA 1500 claim form. The act also requires the Department of Labor and Industry to prescribe a standard form for medical reports to be filed by the provider with the patient's employer.

The cap on medical fees applies to treatment and services rendered to new and existing patients on or after August 31, 1993. After January 1, 1995, medical fee reimbursement rates will be updated annually based upon the percentage change in the statewide average weekly wage, with such updates being cumulative.

Utilization review

Act 44 implements a comprehensive utilization review and peer review procedure, and establishes a new type of utilization review body called a utilization review organization (URO). A URO is made up of an impartial physician, surgeon, or other health care provider or panel of providers. The purpose of a URO is to review the reasonableness and necessity of treatment provided to employees. The act does not address whether the review must be by a member of the same specialty or profession as that provider.

Act 44 provides that peer review may be prospective, concurrent, or retrospective. The wording of the act appears to limit the URO's authority to reviewing medical reasonableness and the necessity of the treatment provided. However, no precise definition of "medical necessity" can be found in the act. Utilization review may be requested by an employee, employer, or insurer.

The act also establishes a detailed process for the peer review procedure. Peer review may be initiated by the workers' compensation judge or any party to the litigation. Peer review organizations (PROs) are randomly assigned to each case from an approved list. The act establishes a comprehensive time frame during which records are requested, hearings held, and determinations made.

The act also repeals a provision of the previous law which required an employer to file a petition with the workers' compensation judge before the employer could cease paying benefits. Under the act, the employer may stop paying benefits as long as the treatment has been challenged to a PRO on a timely basis.

Designated workers' comp physicians

If an employer posts a list of designated providers, a worker who claims injury must be treated by a designated physician or other health care provider for a period of 30 days from the date of the first visit. Under the previous law, there was a 14-day time limitation. The act expands the scope of an employer's list to include at least six physicians, health care providers, or coordinated care organizations (CCOs). Two of the six providers may be CCOs, but no fewer than three must be physicians.

The method for accreditation as a CCO is also spelled out in the act. CCOs must include a distribution of health care providers across various specialties and must have the ability to make referrals to treat injuries that would not normally be covered by primary care services, but are otherwise covered by the act. Such referrals would include dental, chiropractic, and optometry services.

Patient billing prohibited

A provider may not hold an employee liable for health care costs provided in connection with a work-related injury covered by the act unless the employee has failed to comply with his or her obligations under the act.

Reporting requirements

Health care providers treating injured employees must file periodic reports with the employer. Those reports include history, diagnosis, treatment, prognosis, and physical findings. An employer is not required to pay for treatment until the report has been filed.

Member Resource

The Pennsylvania Medical Society—working with the state Department of Health and the state Department of Labor and Industry—has compiled answers to some of the most often asked questions about the Pennsylvania Workers' Compensation Act of 1993. For a copy of the questions and answers, call the Society's Department of Regulatory Affairs and Specialty Legislation at (800) 228-7823 or (717) 558-7750.

An employer must pay the provider for treatment within 30 days of receipt of bills and records, unless the employer disputes the reasonableness and/or necessity of treatment provided. If a provider disputes the amounts or timeliness of the payment from the insurance company, the provider may file an application for review with the Department of Labor and Industry, except if the employer is challenging the reasonableness or necessity of the treatment to a URO.

Anti-referral prohibition

Act 44 contains two prohibitions on referrals by providers. First, providers are prohibited from referring a patient for laboratory, chiropractic, physical therapy, rehabilitation, radiation/oncology, psychometric, home infusion therapy, or diagnostic imaging services or goods if the referring provider has a financial interest with the person, or in the entity, that receives the referrals. The act also contains a broad fraudulent billing and anti-remuneration referral provision.

The department has indicated that the Medicare safe harbor provisions will be recognized as exceptions to the anti-referral prohibitions found in the act. Additionally, exceptions to the Ethics in Patient Referral Act, known as Stark I and II, will also be recognized. The department will also consider implementing other exceptions to the anti-referral prohibitions.

While this review outlines the act's provisions that generally affect health care providers, the act also implements other provisions which may affect physicians in their capacity as employers. Accordingly, physicians should consult with the State Society, their carriers, or counsel if additional guidance is needed to assure full compliance with Pennsylvania's updated workers' compensation reforms.

The contributing author, Nancy W. Miller, JD, is an attorney/consultant with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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Society Continues Efforts to Resolve Primary Care Shortage

The State Society in 1993 developed a 93-page draft of "Recommendations to Resolve the Primary Care Physician Shortage." The report—summarized in the December 1993 issue of PENNSYLVANIA MEDICINE—discusses the shortage, its causes, and current efforts to resolve the shortage, and recommends several long-term solutions.

According to the report, long-term solutions to the primary care physician shortage require simultaneous actions on many fronts, including by medical schools, residency programs, and state and federal governments. The Society also maintains that the Federation of Medicine must play a participatory role and not just advise what others should do. Following is an overview and update of existing Society programs to address the primary care physician shortage.

Lancaster Community Health Plan

This coordinated care pilot project—developed by the Lancaster County and City Medical Society and supported by the State Society—would provide all Medicaid recipients with access to a primary care "medical home" that would also serve as a gatekeeper for other services. The project also includes support services, such as a computerized medical tracking system for immunizations and an after-hours coverage service. For a more detailed look at the project and one of its key players, see pages 36-38.

Health Care Financing Administration approval of the Lancaster Plan is expected on or about February 15, 1994. At press time, a few details of the project remained unresolved by the Department of Public Welfare.

The Society will continue its close collaboration and support of the project, and provide technical assistance to county societies interested in implementing similar pilot projects.

Physician masterfile

The Society's physician masterfile is a comprehensive listing of all physicians licensed, practicing, and/or residing in the commonwealth. The Society shares this information with the Department of Health and organizations working to resolve access problems in Pennsylvania by identifying underserved areas.

One such organization is a task force made up of representatives of the Society, the Hospital Association of Pennsylvania, the Pennsylvania Office of Rural Health, and the Pennsylvania Forum for Primary Health Care. The task force is working to develop a resource guide for regions to use in seeking designation as a Health Professional Shortage Area (HPSA) or a medically underserved area (MUA). Since the number of primary care physicians in a region is important to the determination, the Society is offering the masterfile to track those numbers. Depending on the nature of any particular request, a nominal fee may be required to cover the Society's costs.

Also, the Society has offered the resource to the Robert Wood Johnson Foundation (RWJF) General Physician Initiative at Penn State's College of Medicine, Hershey. Under the initiative, the college is challenged to increase the supply of generalist physicians; the file will be used to track Penn State medical graduates.

HPSA designation process education

As mentioned above, the Society is involved in a task force to develop a guide to assist organizations in applying for HPSA status. The Society believes the guide could be a valuable tool for county societies, to assist them in becoming more active and productive in the identification of underserved areas.

Community/practice opportunity assessment

The Society has developed a handbook which includes checklists and questionnaires that assist physicians in evaluating possible practice location sites using criteria such as population and demographic statistics, educational opportunities for family members, and the availability of cultural stimulation. While the primary focus of the handbook is to aid physicians, it can also be helpful to communities recruiting a physician.

RWJF Practice Sights Initiative Steering Committee

Representatives of the State Society continue to participate in this steering committee formed to assist the Pennsylvania Department of Health in preparing its proposal for a RWJF implementation grant on primary care. The Society is actively helping to finalize the grant proposal and also participating in committee task forces on primary care practitioner team building, community/provider technical assistance, and recruitment and retention of primary care providers.

Future initiatives

As reported in December, the Society is also planning a number of future initiatives as part of its effort to resolve the primary care physician shortage. The Society is planning to:

- encourage and support legislative and regulatory initiatives important to the resolution of Pennsylvania's primary care physician shortage;
- support initiatives for greater availability and utilization of physician extenders, provided adequate safeguards are in place to assure quality through collaboration and supervision by physicians;
- study how it can assist primary care physicians in rural areas to minimize their isolation and the "hassle factor" by forming groups or other practice links with other physicians;
- study the merits of targeting students committed to pursuing careers in primary care for medical education loans provided by its Educational and Scientific Trust; and
- explore the merits of a project to update Pennsylvania's urban shortage areas.

U.S. PHYSICIANS CONTINUE PUSH FOR REFORM

U.S. physicians remain strongly committed to health system reform, while both supporting and rejecting

various aspects of the Clinton administration's plan to revamp the system, according to a poll released by the AMA in December.

In the poll, conducted in October and November 1993, 83 percent of physicians supported the Clinton plan on features that would extend coverage and access to Americans. A majority of physicians thought the plan would be either "very effective (29 percent) or "somewhat effective" (46 percent) in ensuring care for all Americans.

Among the features supported by physicians:

- no denial or loss of coverage for any reason (91 percent);
- a comprehensive benefit package (78 percent);
- access to a wide choice of health plans, and with extra fees, to a wider choice of physicians and hospitals (70 percent);
- an employer mandate (70 percent);
- limits on the growth of health insurance premiums (55 percent); and
- liability reform requiring the use of alternative forms of dispute resolution (87 percent).

On other aspects of the administration's plan, physicians were more critical. Principal areas of opposition were:

- cuts in Medicare and Medicaid (81 percent);
- creation of a National Health Board (56 percent);
- allocation of resident training positions by the government (62 percent);
- a system of mandatory alliances (55 percent); and
- a national health care budget that limits the growth of expenditures (52 percent).

Fifty-two percent of responding physicians said patients would fare "worse" under the plan, while only 19 percent thought their patients would benefit, 24 percent expected patients to fare "the same," and two percent expressed no opinion. The results indicate that the better physicians feel patients will fare under the plan and the more they feel the plan would be effective, the more positive physicians are toward the plan.

Additional analysis revealed skepticism about the likely success of the plan in controlling health care costs, with four percent of respondents predicting "very effective" in maintaining quality, while 40 percent feared the plan would be "very ineffective" in upholding quality standards. Seventy-one percent of physicians interviewed thought the administration plan did not go far enough on liability reform because it did not include a cap on non-economic damages.

Asked for an overall reaction to the plan, 44 percent of physicians said their reaction was negative, 32 percent were "neutral," and 22 percent said their reaction was positive.

TEN "DEVILISH DETAILS" LISTED FOR CONGRESS

Congress needs "to work the devil out" of 10 AMA priorities to ensure meaningful health system reform, AMA Executive Vice President James S. Todd, MD, told delegates at the House's Interim Meeting in New Orleans in December.

"I hope they're listening up there in Washington, on both ends of Pennsylvania Avenue," Dr. Todd said. "I want them to get out a pencil and paper, because I have a list of 10 details they had better work the devil out before any kind of reform is going to work."

The 10 "devilish details" Dr. Todd listed for Congress include:

1. Avoid new bureaucracies that intrude on the traditional patient-physician relationship.
2. Give negotiating power to physicians.
3. Eliminate spending limits that limit care.
4. Keep medical decision making in physicians' hands, not in the hands of giant insurance companies.
5. Build national quality standards around medical, not economic, issues.
6. Guarantee fee-for-service option for patients.
7. Take caution when deciding ratios of primary care physicians to specialists.
8. Simplify administrative "hassles."
9. Reform medical liability laws to include caps on jury awards and lawyer fees.
10. Ensure universal access to care for all Americans.

Dr. Todd advised delegates before deliberations began at the meeting, saying, "If the business before you advances reform, then do it. But if it gets in the way, or wastes our energies, or is just plain frivolous, set it aside for a later time...Do not divert us from our primary purpose—health system reform."

PHYSICIANS, POLICY MAKERS TO MEET IN WASHINGTON

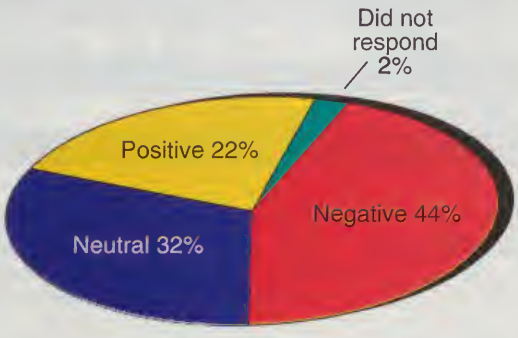
The American Medical Association (AMA) will host an interactive meeting of physicians and key congressional policy makers in Washington, DC, on March 8. The theme for the day-long meeting is "Partnership in Action: Uniting for America's Health."

According to AMA President Joseph Painter, MD, the meeting will allow physicians to exchange views with the key players in the health system reform debate. "Specific health care reform proposals are being hammered into policy," he says. Now is the time to ask questions and voice concerns."

The meeting will be held at the Stouffer Mayflower Hotel. For more information about program content or fees, or to register, call the AMA at (800) 262-3211.

Physician Reaction to U.S. Health Security Act

The majority of U.S. physicians reacted negatively or were neutral about President Clinton's proposed Health Security Act, according to an AMA physician poll released in December 1993.



State Society Offers Drug Cost Information

Physicians across the state agree that they need an unbiased source of information on prescription drugs. Based on the results of a recent statewide survey, Pennsylvania physicians are especially interested in reliable drug cost information. In response, the State Society's Center for Professional Drug Education and Information will periodically publish in PENNSYLVANIA MEDICINE cost information for medications in various drug classes. The first drug class in this series is nonsteroidal anti-inflammatory drugs (NSAIDs).

NSAIDs are most commonly prescribed for their anti-inflammatory effects; however, they are also effective analgesics and are useful for the relief of mild to moderate pain. Clinically, there are no clear guidelines to assist in selecting the most appropriate NSAID for a patient. Physicians should base selection on clinical experience, patient convenience, side effects, and cost.†

The chart below presents the average wholesale price of a one-month regimen plus a $3.00 dispensing fee. While prices vary from pharmacy to pharmacy and region to region, this chart provides physicians with a means for making relative comparisons among NSAIDs. The drugs are listed in alphabetical order by brand name.

For a free pocket card or wall chart version of this information on NSAIDs, contact the Society's Center for Professional Drug Education and Information at (717) 558-7750 or (800) 228-7823.

†*Drug Facts and Comparisons, 1994 Edition.* Facts and Comparisons, A Wolters Kluwer Company, St. Louis, MO, 1994, p. 1210.

The Center for Professional Drug Education and Information was established to assist in retrospective drug utilization review for Pennsylvania Medicaid prescriptions and to provide Pennsylvania physicians with an alternate, non-biased source of information on prescription medications. The Society is working with the Pennsylvania Department of Public Welfare and Health Information Designs, Inc., on this program. Our goal is to help physicians make better prescribing decisions through education.

Nonsteroidal Anti-Inflammatory Drugs: Cost Comparison of One Month of Therapy

BRAND NAME	GENERIC NAME	ADULT DOSING	QUANTITY	BRAND COST	GENERIC COST
Anaprox	Naproxen Sodium	275 mg BID	60	$45.78	NA
Ansaid	Flurbiprofen	50 mg QID	120	$87.55	NA
Ascriptin	Aspirin	325 mg QD 12 tablets QD	360	$34.21	$11.84
Clinoril	Sulindac	150 mg BID	60	$56.81	$46.54
Daypro	Oxaprozin	600 mg QD (2 tablets)	60	$67.38	NA
Dolobid	Diflunisal	500 mg BID	60	$51.85	$58.33
Disalcid	Salsalate	750 mg QID	120	$55.92	$14.88
Feldene	Piroxicam	20 mg QD	30	$71.61	$64.52
Indocin	Indomethacin	25 mg TID	90	$46.63	$10.50
Lodine	Etodolac	300 mg QID 200 mg TID	120 990	$124.59 $82.87	NA NA
Meclomen	Meclofenamate	100 mg TID	90	$91.73	$19.22
Motrin	Ibuprofen	600 mg TID	90	$28.30	$15.52
Nalfon	Fenoprofen	300 mg QID	120	$70.39	$42.45
Naprosyn	Naproxen	250 mg BID	60	$45.92	NA
Orudis	Ketoprofen	50 mg QID	120	$121.81	NA
Relafen	Nabumetone	500 mg BID	60	$57.00	NA
Voltaren	Diclofenac	75 mg BID	60	$60.65	NA

Notes

Cost = Average wholesale price plus $3.00 dispensing fee.
Dosage and duration may have to be adjusted for disease severity, age, and/or co-morbid conditions.
NA = not available.

Source

1993 Red Book Drug Topics Update. Medical Economics Company, Oradell, New Jersey.

This comparative table was assembled by Health Information Designs, Inc. (HID)—a firm specializing in drug utilization review, based in Fairfax, Virginia—who is a partner in the Pennsylvania Medicaid Retrospective DUR program. *Copyright 1993, The Prescription Drug Education Project.*

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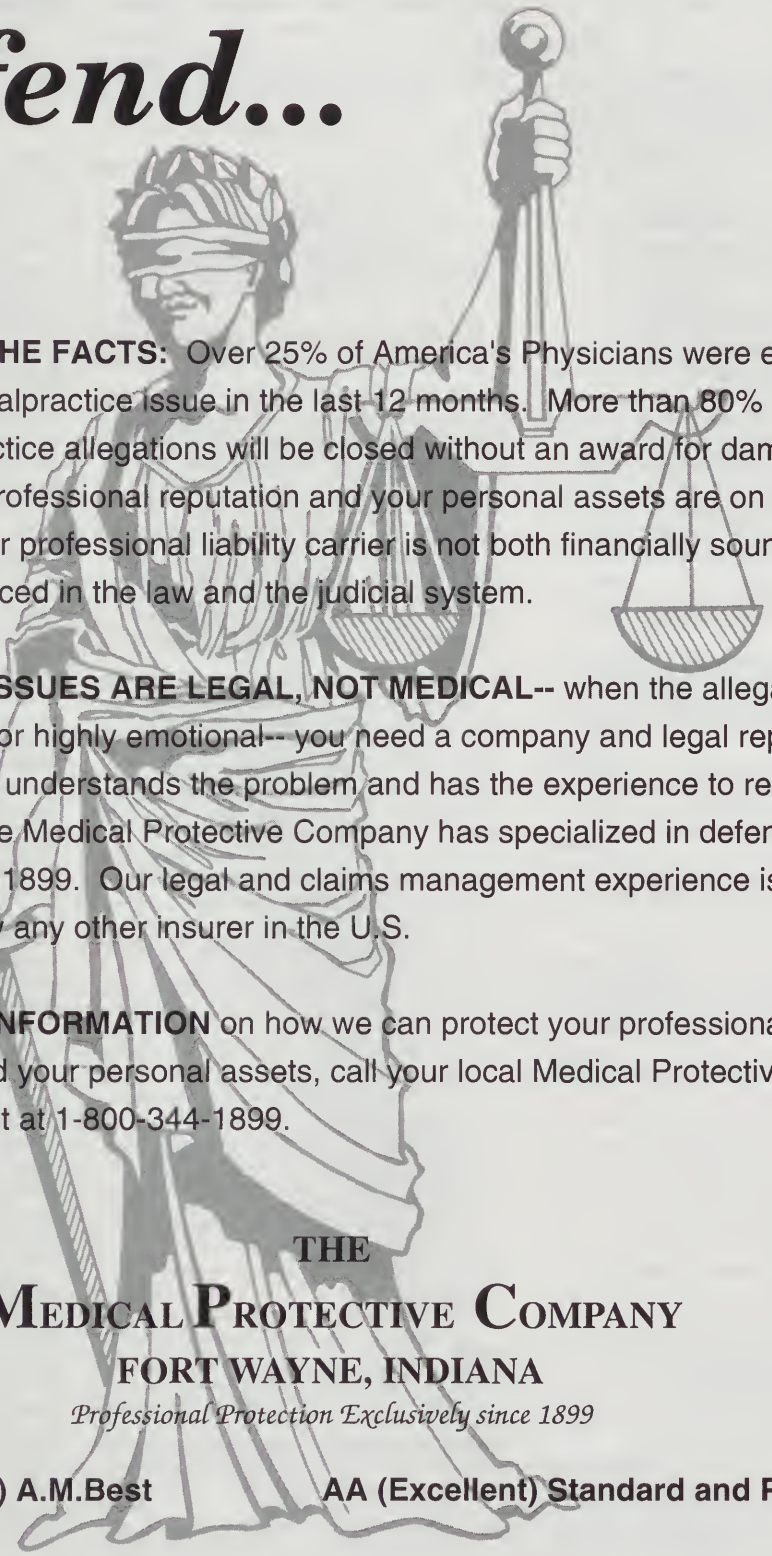

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REMINDER

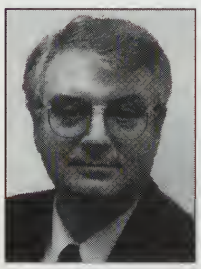
Registration deadline for the Society's 1994 Spring Assembly is **March 18**. Registration forms were included in the February issue of *Executive Report*. Additional forms are available by calling the Society at (800) 228-7823 or (717) 558-7750.

NEWSMAKERS

Gordon K. McLean, MD, chief of interventional radiology at the Western Pennsylvania Hospital, Pittsburgh, testified before the U.S. House of Representatives' Ways and Means Committee's Subcommittee on Health to offer the views of interventional radiologists on President Clinton's health system reform proposal.

The Medical College of Pennsylvania, Philadelphia, promoted **Anthony J. Piraino, MD,** professor of pharmacology and chief of clinical pharmacology, to professor of medicine.

James B. Carty Jr., MD, chief of ophthalmology, Bryn Mawr Hospital, Philadelphia, received an Honor Award from the American Academy of Ophthalmology for his contributions to the academy and to the field of ophthalmology.



Dr. Mayer

Nathaniel H. Mayer, MD, director, Drucker Brain Injury Center, MossRehab Hospital, Philadelphia, has received the Sheldon Berrol Clinical Service Award from the National Head Injury Foundation for his life-long work to improve the quality of care for people who have sustained traumatic brain injury.

Wills Eye Hospital, Philadelphia, has promoted the following: **Mark H. Blecher, MD,** from assistant surgeon to associate surgeon on the Cataract and Primary Eye Care Service; and **Robert B. Penne, MD,** from assistant surgeon to associate surgeon on the Oculoplastic Service.

Frank W. Bowen Jr., MD, chief of newborn pediatrics, Pennsylvania Hospital, Philadelphia, was honored as the March of Dimes Citizen of the Year.

T. Rogers Kyle III, MD, was appointed chief of internal medicine, Chestnut Hill Hospital, Philadelphia.

James R. Roberts, MD, was appointed vice-chair, Department of Emergency Medicine, Medical College of Pennsylvania, Philadelphia.

Dr. Koprowski

Hilary Koprowski, MD, director, Center for Neurovirology, Thomas Jefferson University, Philadelphia, was honored for over 45 years of dedicated rabies research. Dr. Koprowski and his colleagues were the first to develop a safer, less painful, and more effective rabies vaccine for humans.

Michael J. O'Connor, MD, chief of neurosurgery, The Graduate Hospital, Philadelphia, was honored by the Epilepsy Foundation of Southeastern Pennsylvania for his "substantial contribution toward improving the quality of life for people with epilepsy."

Robert W. Muir, MD, Reading, was appointed Pennsylvania (Area E) State Chairman of the American College of Surgeon's Cancer Liaison Program.

Vincent J. DiStefano, MD, chairman of orthopedic surgery, The Graduate Hospital, Philadelphia, was selected to be included in the second edition of *The Best Doctors in America*.

Julia McMillan, MD, deputy director, Department of Pediatrics, and director of the residency training program, Johns Hopkins University Hospital, Baltimore, Maryland, has recieved the first David S. Smith, MD, Visiting Professorship at Temple University School of Medicine, Philadelphia.

Robert F. Ozols, MD, was named senior vice president for medical sciences at Fox Chase Cancer Center, Philadelphia.

The Joint Reconstruction Center of the University of Pennsylvania Medical Center, Philadelphia, has named **Joseph Iannotti, MD, PhD,** interim chairman of the Department of Orthopedics.

The University of Pennsylvania Medical Center, Philadelphia, has created the Nancy and Richard Wolfson Endowed Professorship of the Department of Obstetrics and Gynecology. **Luis Blasco, MD,** medical director of Penn's Andrology Laboratory, Department of Obstetrics and Gynecology, will be the first Wolfson professor.

Jay A. Redan, MD, received a three-year appointment as cancer liaison physician for the hospital cancer program, Tyler Memorial Hospital, Tunkhannock.

Stephen J. Gluckman, MD, was appointed director of infectious disease clinical services, University of Pennsylvania Medical Center, Philadelphia.

Stuart L. Fine, MD, Philadelphia, chairman, Department of Ophthalmology, University of Pennsylvania School of Medicine, and director of Scheie Eye Institute, was awarded a grant of $85,000 from Research to Prevent Blindness. Also, **Dwight Stambolian, MD, PhD,** research scientist and ophthalmologist, University of Pennsylvania School of Medicine, Philadelphia, received the James S. Adams Scholarship, presented by Research to Prevent Blindness, to continue his research of isolating inherited congenital cataract genes.

W. William Shay, DO, Boyertown, has been elected president of the Acupuncture Society of Pennsylvania.

Francis A. Salerno, MD, chief of geriatrics, Lehigh Valley Hospital, Allentown, was selected as the 1993 American Geriatrics Society/Marion Merrell Dow Clinician of the Year.

Columbia University, New York, has awarded a clinical fellowship in human rights and medicine to **Katherine Sherif, MD,** a resident at the Medical College of Pennsylvania.

Albert Zanetti, DO, has been named medical director of Dauphin Manor-Dauphin County Home and Hospital, Harrisburg.

Dr. Rothstein

Kenneth D. Rothstein, MD, staff physician, Albert Einstein Center for Organ Transplant, and assistant professor of medicine, Temple University Medical School, Philadelphia, was named director of the Center for Liver Disease, Albert Einstein Medical Center, Philadelphia.

OBITUARIES

William H. Clark, MD, *Oakmont*
University of Pittsburgh School of Medicine, 1923; age 95, died November 16, 1993. Dr. Clark was a general practitioner.•

Robert F. Norris, MD, *Newtown Square*
University of Pennsylvania School of Medicine, 1932; age 88, died November 24, 1993. Dr. Norris was a pathologist.•

Paul M. Wapner, MD, *Philadelphia*
Temple University School of Medicine, 1939; age 78, died December 5, 1993. Dr. Wapner was an obstetrician/gynecologist.•

Eugene S. Felderman, MD, *Elkins Park*
Jefferson Medical College of Thomas Jefferson University, 1949; age 66, died September 22, 1993. Dr. Felderman was a urologist.

Michael F. Fishter, MD, *Lewistown*
Jefferson Medical College of Thomas Jefferson University, 1955; age 63, died November 10, 1993. Dr. Fishter was a psychiatrist.

Ross M. Gernerd, MD, *Allentown*
Temple University School of Medicine, 1949; age 68, died November 8, 1993. Dr. Gernerd specialized in emergency medicine.

Kenneth H. Heasley, MD, *Titusville*
University of Pittsburgh School of Medicine, 1957; age 61, died October 16, 1993. Dr. Heasley was a pediatrician.

Roy C. Jack, MD, *Carmichaels*
Hahnemann University School of Medicine, 1943; age 74, died September 10, 1993. Dr. Jack was a general practitioner.

Philip L. Mouer, DO, *York*
Philadelphia College of Osteopathic Medicine, 1951; age 69, died September 13, 1993. Dr. Mouer was a general practitioner.

Walter S. Mountain, MD, *Cleona*
Jefferson Medical College of Thomas Jefferson University, 1925; age 94, died October 4, 1993. Dr. Mountain was an ophthalmologist.

Louis A. Pegel, MD, *Flourtown*
New York University School of Medicine, 1949; age 69, died November 1, 1993. Dr. Pegel was a general practitioner.

Charles Shagass, MD, *Wyncote*
McGill University Faculty of Medicine, Quebec, Canada, 1949; age 73, died October 27, 1993. Dr. Shagass was a psychiatrist.

Walter M. Smith, MD, *Richlandtown*
Temple University School of Medicine, 1932; age 87, died September 27, 1993. Dr. Smith specialized in pulmonary diseases.

Silas L. Warner, MD, *Carmel, CA (formerly of Gladwyne)*
Northwestern University Medical School, Illinois, 1949; age 69, died November 21, 1993. Dr. Warner was a psychiatrist.

Israel Zwerlinger, MD, *Philadelphia*
Downstate Medical Center, Brooklyn, New York, 1950; age 76, died November 12, 1993. Dr. Zwerlinger was a psychiatrist.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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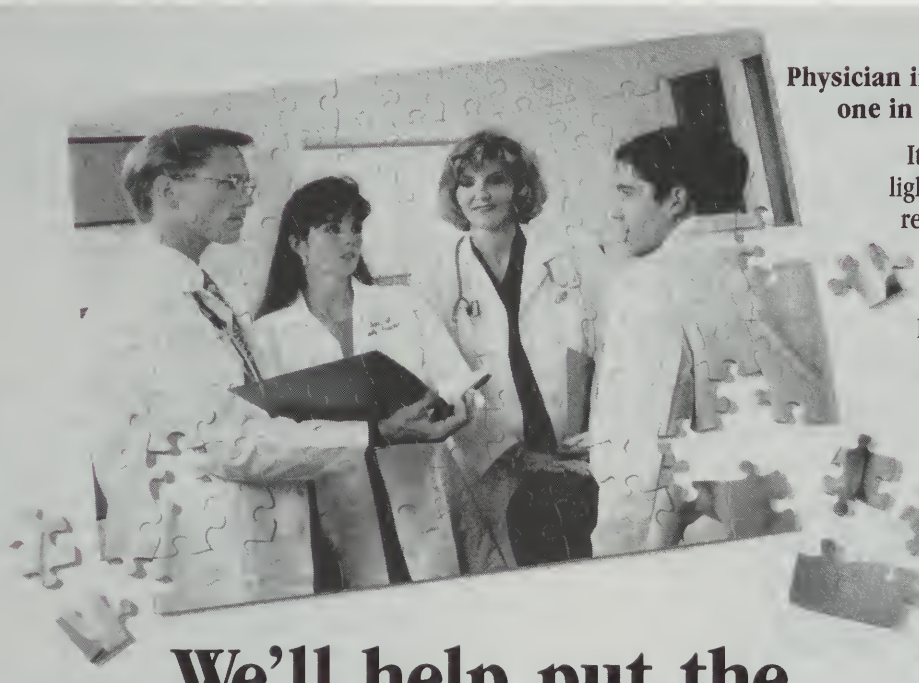

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Western Pennsylvania—Board Certified or prepared emergency physicians needed for staffing a community hospital emergency department near the Ohio/Pennsylvania border. Please send CV to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pennsylvania—Physician group seeks full-time and part-time physicians for an emergency department of community hospitals in central and western Pennsylvania. Please send resume to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pittsburgh, Pennsylvania—Penn Group Medical Association (PGMA), a 100-physician multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physicians in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves eight ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, fringe benefits, and incentives. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222, or call collect (412) 553-7502.

Physician Wanted—Internal Medicine/General Practice must be bilingual English/Spanish physician full- or part-time to join fine busy practice near Philadelphia suburb of Cheltenham. Please call M. Finnegan (215) 549-3000.

Full-time emergency room position available in a 400-bed suburban hospital with 44,000 visits. Board certified/eligible in emergency medicine or other specialty with emergency room experience. Excellent salary/benefit package. Contact: Clarke Hankey, MD, Emergency Department, St. Clair Hospital, 1000 Bower Hill Road, Pittsburgh, PA 15243; (412) 561-4900.

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Emergency Physicians—Emergency Physician Associates is seeking quality ED physicians for a variety of practice opportunities. Director and staff positions are available. EPA contracts with hospitals in NJ, PA, and MD for the provision of emergency medicine, urgent care and industrial/occupational health services. Our client hospitals are located in rural to urban areas with patient volumes ranging from 10,000 to 75,000. At EPA we offer physicians competitive compensation, flexible schedules and shifts, occurrence-based malpractice insurance, a variety of practice settings to choose from, cooperative working environments, and supportive medical directors and corporate staff. Interested candidates may contact EPA at 1-800-848-EPA-1.

Physicians, Excellent Benefits/Bonus Packages—Physicians are needed to fill full-time positions in the field of administrative medicine in the PA Department of Labor and Industry, Bureau of Disability Determination, Harrisburg, PA. Employes serve as a disability claims review physician or a disability specialist physician. Disability specialist physician candidates must have 3 years of experience and/or residency training in the medical specialty or subspecialty practice. All candidates must possess a license to practice medicine in the Commonwealth of Pennsylvania as issued by the State Board of Medical Education and Licensure or the State Board of Osteopathic Examiners. These are civil service positions. For more information, call Ruth Wishard at 717-783-3620 Extension 369 between 7:30 am - 3:30 pm. The Commonwealth is an equal opportunity employer.

General/Vascular Surgeon (BC)—Excellent opportunity for board-certified general surgeon, preferably with special interest in vascular surgery, to associate with senior surgeon. Three BC general surgeons currently cover population of 80,000 people within a 10 mile radius of a beautiful small town close to Baltimore. Contact: Lee Johnson, Vice President of Professional Relations, Hanover General Hospital, 300 Highland Ave., Hanover, PA 17331; 1-800-673-2426, Ext. 4289.

Emergency Medicine Physician—Pennsylvania, suburban Philadelphia. Large community teaching hospital, including burn center, heart program, level II trauma center, and paramedic training institute. 36,000 visits with double and triple coverage. Exceptional compensation and benefits. Must be EM board certified/prepared. Contact Richard McDowell, MD, FACEP, Chairman, Department of Emergency Medicine, Crozer-Chester Medical Center, Upland, PA; 215-447-6253.

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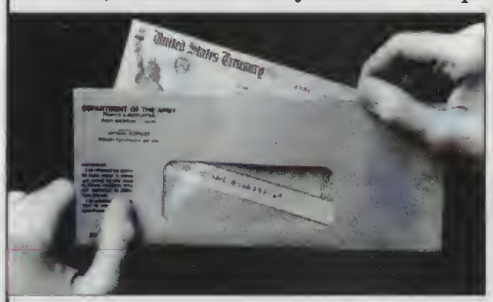

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A Skeptic's Turn: Memorial to a Magnificent Medical Myth

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Health education is a magnificent medical myth! Nineteen sixty-four was my sixth year in clinical solo family medicine, and when the surgeon general's report on cigarette smoking was issued, I confidently felt that since there was no longer any more scientific doubt about the harmful effects of cigarette smoking, thousands would quit. They did—a few for good, lots for a month, many for a week, but most for only a few days. In my medical naiveté, it was incomprehensible to me that intelligent, rational human beings would continue a practice scientifically demonstrated to be harmful to their health.

Since that shock, it has been all downhill. I am now convinced that longevity, freedom from disease, and well-being depend only to the smallest degree upon the active effects of health education. Collective health improvements in the community derive mainly from the great sanitary advances: pure water, adequate sewage disposal, mandatory food inspection, and other similar measures. Adequate housing, clothing, and nutritious food also contribute to the overall picture of improving health. Immunization is another program which has preserved millions of lives.

When an individual is faced with a health decision which requires the sacrifice of some part of their lifestyle, the whole picture changes. Everyone knows that smoking cigarettes is harmful. The cost of this voluntary health-damaging activity in terms both of human life and medical costs is staggering—billions of dollars yearly, and thousands of lives.

Radio and television advertisements have been banned, warnings have been placed on cigarette packs, and smoking is being banned in more public places. What is the effect of all this educational exposure? Need I tell you?

Consider the AIDS situation. We are currently entertaining a national venereal disease epidemic. Has health education had more than a minuscule effect in this area? Alcoholism, the real drug problem, is a disease almost as old as man himself and is becoming increasingly prevalent. Other drugs of abuse are used with varying degrees of regularity depending upon the availability of the drugs and the diligence of the law enforcement programs—not upon health education.

On and on we could go, but I'm sure you understand the point I am striving to make here. A generation of school children, taught the basis for a good diet, flocks to fast-food chain restaurants where salt, sugar, and fats are served in abundance. Despite the well-known and proven protective effect of fluoridation, dental disease is still a problem. Obesity is a national disease, as is lack of exercise, especially in regard to our children.

You may point to the decrease in cardiovascular deaths as an example of education leading to improvement in health. However, we know that many diseases follow a wax and wane pattern, and it appears that the decline in CAD mortality began even before the exercise and healthy eating thing began.

Do you wonder why I heave a deep sigh when yet another government task force is announced which produces hundreds of pages of testimony devoted to the same tired educational recommendations? More health education in the schools, more lectures, pamphlets, seminars, etc.

The health planners are fooling us. Those who profit most from these grand schemes include paper manufacturers, copy machine companies, and computer industries.

The real factors which have the greatest effect on our health and longevity appear to be heredity, environment, and lifestyle. There is nothing we can do individually about the first, we seem to have progressed somewhat with regard to the second, but we have not a good track record with regard to the third. ○

Dr. Davis, a former Society trustee, is a family physician at Geisinger Medical Center, Danville.

1994

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MARCH 1994

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Special Insert: Upgrading Diabetes Therapy...What Physicians Need to Know—page 34
State Society Supports Your Interests in Court—page 24

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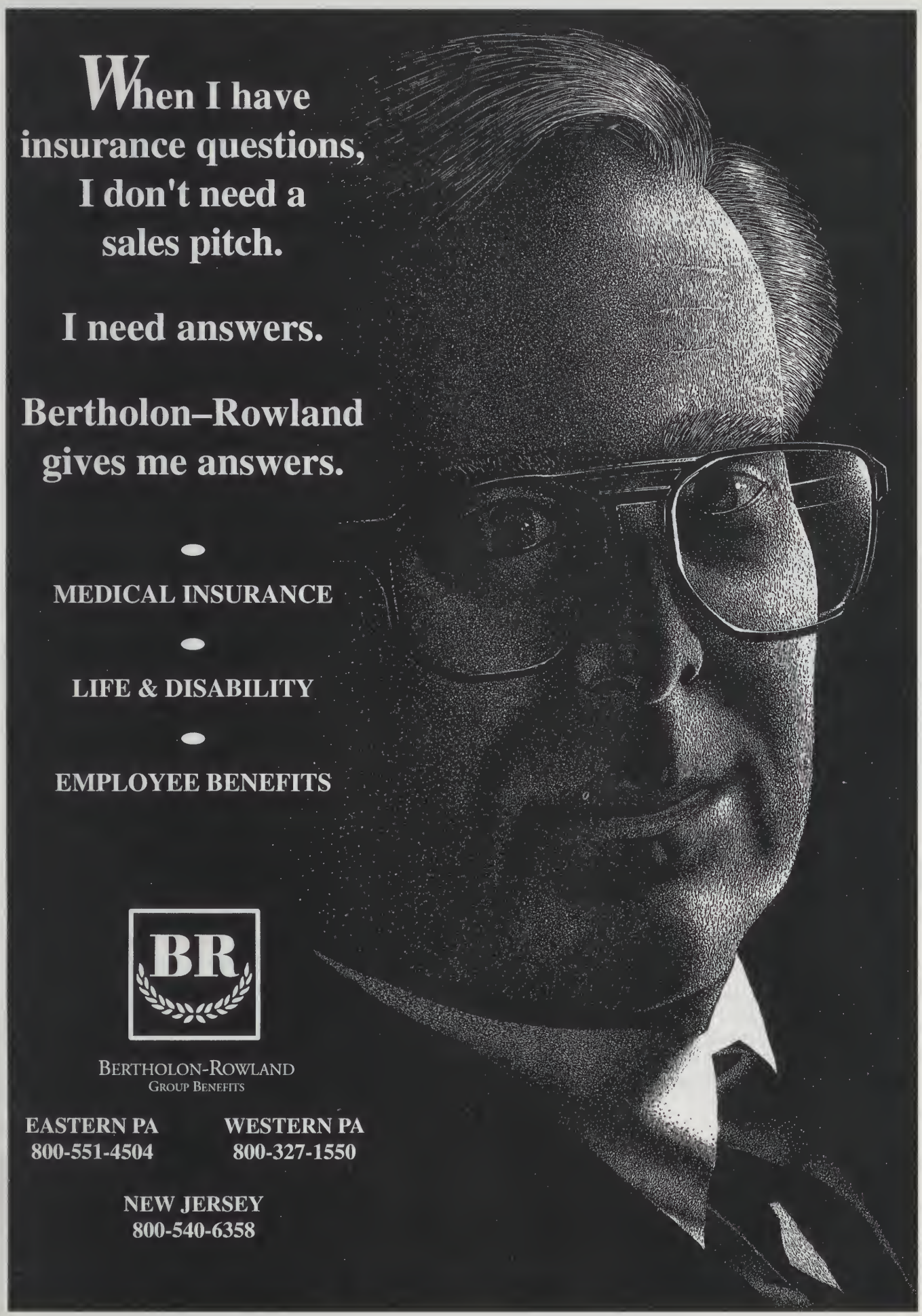
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Cover by SpectraComp, Mechanicsburg

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Donald H. Smith, MD

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For the past 34 years, LeRoy Erickson has served the State Society in a number of positions, most recently—and most notably—as executive director of The Educational and Scientific Trust. Prior to his retirement in February, he talked to us about his work at the Society and the satisfaction of leaving something behind that is lasting.

LeRoy Erickson

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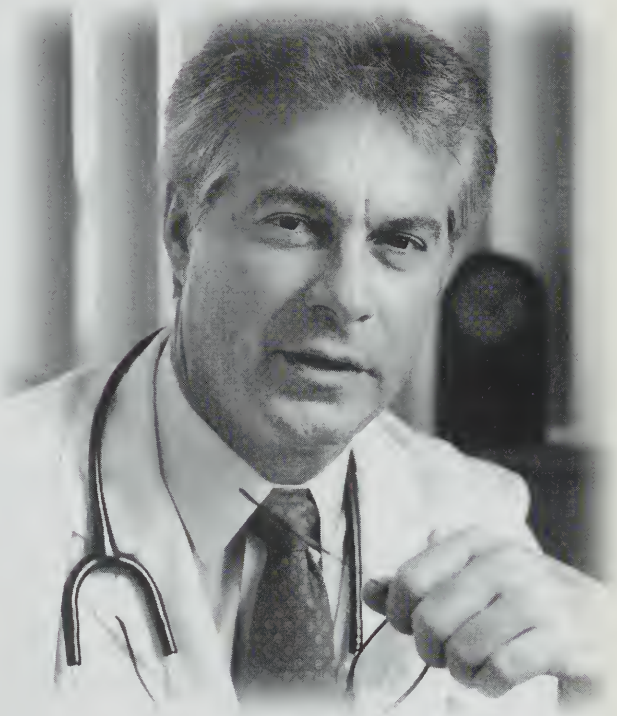
"Unfortunately,

he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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COSPONSORS SOUGHT FOR U.S. ANTITRUST BILLS: *THE SOCIETY IS URGING PHYSICIANS TO CONTACT THEIR U.S. SENATORS AND REPRESENTATIVES TO COSPONSOR S. 1658 AND H.R. 3486,* two bills aimed at ensuring that physicians and their patients—not government, insurance companies, or corporations—control patient care in any reform proposal. The Society says there are many dangers which might result from large-scale reform of the U.S. health care delivery system, including the possibility that important patient care decisions will be governed not by clinical necessity, but rather by the financial bottom line. The Society suggests that physicians include the following in their correspondence: 1) physicians must be relieved of antitrust constraints and afforded "safe harbor" protections, so their clinical concerns are given full consideration; 2) health plans should be required to establish a medical staff with defined rights regarding the plan's medical policy, utilization, quality, and credentialing and management issues; and 3) financial and regulatory barriers must be removed to support the development of physician-sponsored networks and insurance plans. Physicians should also outline examples of the restraints they face under the current antitrust law. Please copy any correspondence to the Society.

SENATE COMMITTEE DEBATE FOCUSES ON LIABILITY REFORM: State Society President Martin A. Murcek, MD, and PMSLIC Board Chair Betty Cottle, MD, were among eight panelists to testify at a state Senate Public Health and Welfare Committee meeting on medical liability reform conducted by Committee Chair Senator Hardy Williams (D-Philadelphia) on February 23. The Society, taking a "pro-reform" stance, testified on the excessive costs of litigation in the current civil justice system, the high cost of defensive medicine, and the need for reform to protect providers as decisions in managed care systems become more economical rather than clinical in focus. PMSLIC President Sarah Lawhorne, Esq., also testified pro-reform on behalf of the Defense Institute. Although legislation was discussed, Senator Williams has not yet scheduled a specific bill for committee vote.

BEAVER COUNTY GRANTED FEDERAL TAX EXEMPTION: Through Society efforts, the Beaver County Medical Society on February 7 was granted a federal tax exemption under Section 501(c)(6). The IRS initially rejected the county society's tax exemption application. For more information on this and other Society legal activity, see pages 24-25.

SOCIETY COSPONSORING SYMPOSIUM IN APRIL: The Society is cosponsoring a symposium to be held April 15-16, 1994, at the Dickinson School of Law, Carlisle. Entitled "Genetic Engineering: Prescription for Perfection or Roadmap for Disaster?," the symposium will feature nationally known speakers discussing the medical, ethical, and legal implications of genetic engineering and the Human Genome Initiative. For information, call the Society at (800) 228-7823.

DOCTOR'S DAY KITS AVAILABLE TO COUNTY SOCIETIES, HOSPITALS: Publicity kits for county medical societies and hospitals are available to use in celebrating Doctor's Day, nationally recognized each year on March 30. The Society is also requesting the governor's proclamation, and the state alliance (PMSA) and county alliances have scheduled a variety of events. For more information on Society activities, call the Department of Public Affairs at (800) 228-7823. For information on local events, call your county alliance office, or PMSA at the number above.

SPRING ASSEMBLY REGISTRATION DEADLINE QUICKLY APPROACHING: March 18 is the last day to register for the Society's Spring Assembly, "Forging Alliances...Assuring Your Future," to be held April 19-20, 1994, at the Harrisburg Hilton and Towers. Richard F. Corlin, MD, vice speaker of the AMA House of Delegates and immediate past president of the California Medical Association, will offer the keynote address, "What is the Future?" For program information, see pages 42-43. To register, call the Department of Meeting Services at (800) 228-7823 or (717) 558-7750.

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Further Thoughts on Health Reform

John W. Mills, MD
Medical Editor

In his State of the Union message, President Clinton once again focused nationwide attention on health system reform, and rather emphatically, with his pen, "drew a line in the sand" as a formidable challenge to Congress.

Debate over this issue had become low-key since the president's package was presented to Congress last September. However, the pace quickened in December at the AMA interim meeting in New Orleans. Clinton quickly "made hay" over the AMA debate by calling together, at a "staged" Washington news conference, a number of national physician groups who "support" his plan. In the spirit of the NFL Super Bowl, it was a nice end-run around the AMA, but more subtly and more importantly, he was splitting us into factions.

"We have fought among ourselves and made it known—divided our course. For what?"

Of course, the AMA's health reform debate—healthy for all federation members and for each one of us, member or not—was reported as division in the ranks, and organized medicine took a direct hit.

Make no mistake about it, Mr. Clinton is a skilled politician who will play the odds and use any tactic to cajole Congress and divide the health provider community—physician against physician, specialist against specialist, nurse against physician, physician against hospital, and so on, ad infinitum.

A good example of physician-against-physician strife occurred recently on a smaller scale in our own State Society. A resolution adopted by the 1993 House of Delegates calls for a statewide charge class for Medicare patients, replacing the four-tier charge class in place since Medicare's inception. Philadelphia and Allegheny County physicians are paid the highest fee (in simple terms), while rural physicians are paid the lowest fee for the same code or procedure. There are two intermediate class areas used for counties of intermediate size, and the few remaining are somewhere in between the highest and lowest.

State Society staff have completed the complicated process required by HCFA to petition for a statewide charge class. While the House action was not unanimous, the democratic process assures reasonable equanimity.

Philadelphia County Medical Society has opposed the change and expressed this objection to HCFA. This is certainly their right. However, HCFA will perceive our division, and you can be sure other areas of the federal government will also take note—including the Clintons.

My own thoughts on this are straightforward. We have fought among ourselves and made it known—divided our course. For what? If we get any type of federal health system reform, we'll surely have a *nationwide charge class*, with little to say about it.

If you have been following state health reforms around the country, you will have seen some signs of trouble on several fronts. These signs should be warnings to the citizens of this country, as well as to us and our profession.

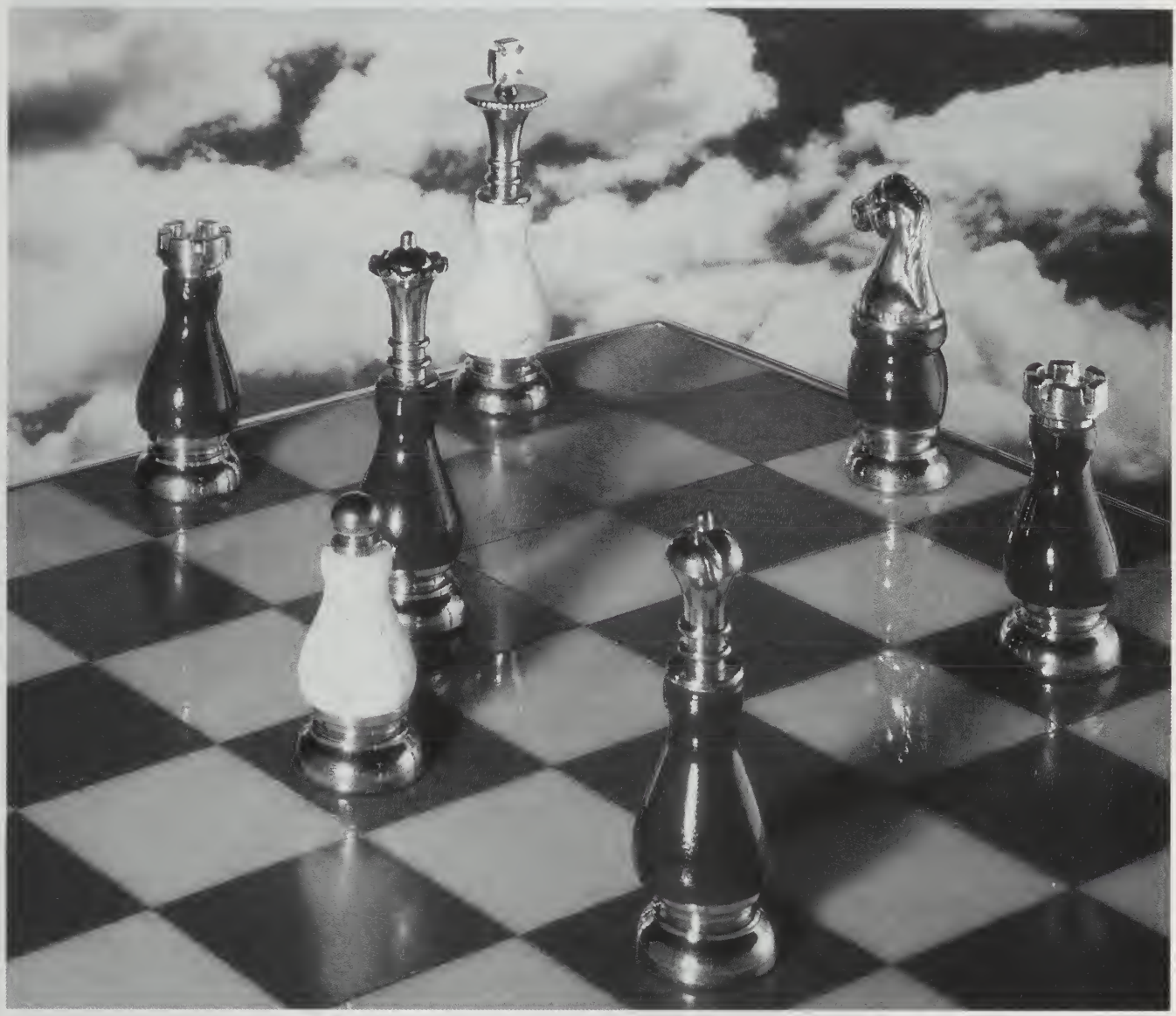
For instance, while physicians in Vermont wholeheartedly supported the single-payer system, put forth by the legislature, for a seat at the table, the system is rapidly being implemented without them! And, TennCare of Tennessee has already lost physicians who signed up a year ago—problems with reimbursement and approval for medically necessary treatment.

It sounds like lots of fun ahead...maybe "nightmare" would be more realistic. Fifty different state plans with a super-imposed federal system will be a real "mish-mash." Portability? I doubt it without a mess of red tape. Mass confusion? You bet!

I've said it before and don't be surprised to read it again and again: We have the largest audience in the country—our patients—and each one of us must answer their questions honestly and convincingly about these issues.

Insurance reform, antitrust reform, tort reform, simplification, and standardization. These reforms we need now. Once they are in place, the system can be fine-tuned and continue to be the finest health system in the world.

That is the thrust of the AMA's debate and stance. Fellow members, physicians nationwide, *unite*. It's our only chance.



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Physician-Assisted Suicide: *Protecting Patient Interests*

Martin A. Murcek, MD

While the public and political debate about providing access and funding for medical care for all Americans continues, another related issue is being discussed apace: The medical community's role in helping patients *end*, rather than prolong, their lives.

The recent news coverage of the activities of "physician-assisted suicide" advocate Dr. Jack Kevorkian has unfortunately been predictably topical and sensationalistic, with more emphasis on the macabre mechanics of suicide than upon the tough philosophical and ethical problems at the heart of the issue.

Martin L. Cook, PhD, in an editorial for the *Archives of Internal Medicine* [December 23, 1993], noted that advances in medical technology "have raised for many patients the specter of spending their final hours, days, or months as captives of a mindless medical system, more clever than wise, that will sustain their lives beyond all reason."

Setting aside for the moment the problem of deciding how to allocate medical resources among "the living" and "the dying," I'd like to look at the efforts, or lack thereof, on the part of traditional sources of moral and ethical wisdom, to contribute to this debate in a constructive fashion.

In *Religion In A Changing World,* Abba Hillel Silver notes that "moral standards are changing in our day." The general trend is one of breakdown, Hillel asserts, brought on by the relative prosperity of our society. The thrust of the analysis is that, in the modern world, life is cheaper than ever. That analysis was written in 1930!

Unfortunately, all that is offered by the spiritual community today is that same tired lament that our world is too materialistically and technologically oriented to sustain a philosophical renaissance that can address the death-and-dying issue head-on. We again have observers willing to describe the problem but unable to recommend any solutions.

If moral leaders who refuse or are unable to lead aren't bad enough, we have to deal with those who tend toward shameless self-promotion, as well.

Political, legal, and social factions in Pennsylvania recently fought a long-winded, bruising, and costly battle over the issue of "living wills"—documents that allow individuals to specify what efforts are to be made, or not made, on their behalf when death is imminent. As with all social debates, the usual suspects lined up to lobby government to write their particular brand of religious dogma into law, create a new client category, open new bureaucratic and regulatory vistas (and jobs), or absolve them of legal, if not moral, responsibility for their actions (or lack thereof).

Another article in the same issue of *Archives of Internal Medicine* discusses "physician-assisted suicide" and "voluntary active euthanasia" in terms of a patient's ability to rationally request how his or her physician responds to the end stages of terminal illness. The main point of the article is that the physician's hands are almost always tied by legal issues that claim concern for the patient, but seldom deliver on that claim.

There are too many people in our society today who, having discovered that they are not qualified to *do* anything in particular, attempt to make careers for themselves out of regulating the doings of others. Such people are not part of the solution to society's problems; they *are* one of its problems!

In the end, I believe the physician must always walk a fine line between responsibility to the patient and fidelity to his or her own moral/ethical code. There's nothing unethical about being totally opposed to suicide or euthanasia in all cases, but there's nothing ethical about forcing that opposition upon someone who is suffering physical pain and emotional anguish in the terminal stage of illness or infirmity.

Once again, it is the medical community's responsibility to share with the public its unique experience, so that the interests of society and the patient are protected. ⬡

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Impact of Nationwide Trials on Office Practice of Heart Disease
Robert Frye, M.D.
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March 9th
Thyroid Nodules
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology and Metabolism
University of Massachusetts Medical School
Worcester, MA

March 16th
Peripheral Vascular Disease
Nicholas P. Tsapatsaris, M.D.
Clinical Instructor of Medicine
Harvard School of Medicine
Head, Section of Vascular Medicine and Hypertension
Lahey Clinic Hospital
Burlington, MA

David Naide, M.D.
Associate Professor of Medicine
Department of Medicine
Hahnemann University

Steven Christensen, M.D.
Assistant Professor of Medicine
Department of Medicine
Hahnemann University

March 23rd
Osteoarthritis: Diagnosis, Medical Management, Arthroscopy and Surgical Indicators
Vincent Zarro, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Rheumatology and Immunology
Hahnemann University

Arnold Berman, M.D.
Professor and Chair
Department of Orthopaedic Surgery and Rehabilitation
Hahnemann University

Albert A. Weiss, M.D.
Associate Professor of Orthopaedic Surgery and Rehabilitation
Hahnemann University

March 30th
Monotherapy of Hypertension
Barry H. Materson, M.D.
Professor of Medicine
University of Miami School of Medicine
Associate Chief of Staff for Education
Miami VA Medical Center
Miami, FL

APRIL 1994

April 6th
Intensive Treatment of Insulin Dependent Diabetes Mellitus
Robert J. Tanenberg, M.D.
Clinical Associate Professor of Medicine
Georgetown University School of Medicine
Medical Director, Diabetic Treatment Center
Washington Hospital Center
Washington, DC

Implications for the Elderly Diabetic
Jesse Roth, M.D.
Lublin Professor of Medicine
Director, Division of Geriatric Medicine and Gerontology
Johns Hopkins School of Medicine
Baltimore, Maryland

April 13th
Coronary Artery Disease
Bernard J. Gersh, MB, ChB, DPhil, FRCP
W. Proctor Harvey Teaching Professor of Cardiology
Chief, Division of Cardiology
Georgetown University School of Medicine
Washington, DC

April 20th
Rheumatoid Arthritis: Common vs. Rare Manifestations
Steven Berney, M.D.
Professor of Medicine
Section of Rheumatology
Temple University School of Medicine
Philadelphia, PA

April 27th
Glomerular Diseases: Present Concepts and Future Directions
William Couser, M.D.
Professor of Medicine
Head, Division of Nephrology
University of Washington School of Medicine
Seattle, WA

MAY 1994

May 4th
Collagenous and Lymphocytic Colitis
Francis M. Giardiello, M.D.
Associate Professor of Medicine
Division of Gastroenterology
The Johns Hopkins School of Medicine
Baltimore, MD

May 11th
Similarities Between Atherosclerotic Plaque Growth, Restenosis and Neomicrocirculation
Valentin Fuster, M.D., Ph.D.
Arthur M. & Hilda A. Master Professor of Medicine
Director, Cardiovascular Institute
Vice Chairman, Department of Medicine
Mt. Sinai Medical Center
New York, NY

May 18th
Glomerular Diseases: Present Concepts and Future Directions
William Couser, M.D.
Professor of Medicine
Head, Division of Nephrology
University of Washington School of Medicine
Seattle, WA

May 25th
Atherosclerosis in Diabetes: Effective Prevention
Alan J. Garber, M.D., Ph.D.
Professor of Medicine, Biochemistry and Cell Biology
Baylor College of Medicine
Houston, TX

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Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair of Medicine, Director, Continuing Medical Education for the Department of Medicine

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RECOGNIZING THE REALITY OF ADDICTIVE DISEASE

My writing this letter is precipitated by three events which came to my attention in rapid succession within the past several weeks.

1) A call from an attorney consulting me about a case of malpractice. His client is a young woman—an executive secretary—who had been sober for eight years following successful treatment of alcoholism. She developed a chronic cough and sought medical treatment, telling her physician she was a recovering alcoholic and must avoid addictive medications. He prescribed Hycodan, refilling her prescription for six ounces, four times within a three-week period.

By the end of the second week, the young woman was confused and making gross mistakes at work. When her employer confronted her with the drastic change in her behavior, she broke down and told him of her history of alcoholism and that she was now taking cough medication. She was promptly fired. She is now suing her physician for prescribing a highly addictive drug after she had told him she was an alcoholic. According to the attorney, the physician is claiming he was unaware that Hycodan is addictive.

2) A 31 year-old woman admitted for relapse of narcotic addiction. She had been "clean" for three years and had extensive dental work done. She told the dentist that she was a recovering addict, and he gave her a prescription for 12 tablets of Percocet, which she consumed within 24 hours, and was back at her drug-seeking behavior.

3) A 42-year-old accountant admitted *because of* severe benzodiazepine addiction. He had been treated for alcoholism and was four-years sober when he began having anxiety attacks. His physician prescribed Xanax, and when asked if he could take this medication with his history of alcoholism, he was told not to worry.

In all three cases the patient was the victim, having been thrown into relapse by well-intending physicians. In case one, the physician may also be a victim, since a defense that he was ignorant that Hycodan is addictive is not likely to be of much help in a malpractice suit.

The real culprit in all three cases is *the educational system,* both at the graduate and post-graduate level, which fails to give adequate instruction on addictive diseases. There are fairly valid statistics that perhaps *one-third* of all general hospital days are due, in one way or another, to the consequences of alcoholism and other chemical dependencies.

Logic would conclude, then, that approximately 30 percent of the medical curriculum should be devoted to these conditions, but we might compromise for 15, 10, or even five percent. Is it not unconscionable that in many medical schools the time allotted for diseases that are responsible for *30 percent* of all hospital days is *.05 percent* of the curriculum, hardly enough to be noticeable?

Many physicians discover that they have been short-changed, and obtain more information on their own by reading and attending seminars. Others rely on what should have been an adequate medical education, and may wake up to find themselves defendants in malpractice suits.

My plea is for medical and dental schools to recognize the reality of addictive disease and prepare doctors and dentists to recognize them, and for all graduate programs to include addictive diseases in their training programs. I strongly urge hospitals, medical societies, and dental societies to pick up the slack and sponsor seminars on addiction.

Let me close with just two nuggets to help avoid mishaps such as those in the three cases cited.

1) Once a person has been an alcoholic/drug addict/chemically dependent person, he/she has a high vulnerability for relapse for the rest of his/her life.

2) Cross-addiction is a fact of life. A person who has been addicted to any mood-altering chemical is a high risk for becoming addicted to any other mood-altering chemical.

But let these two nuggets not comprise our entire knowledge about addictive diseases.

Abraham J. Twerski, MD
Aliquippa

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Casey's Reform Proposal Holds Pitfalls for Pennsylvania Physicians

In the year since announcement of Governor Casey's health reform proposals, much state as well as national debate has occurred. As debate continues, the governor's, as well as the State Society's, proposals are being refined. This synopsis of our views on Senate Bill 1202 and House Bill 1958—to be continued next issue—is an update of our response to Casey's proposal as of January 1994. Next issue, we will address insurance market reform, bureaucratic intervention, quality assurance, practice parameters, limited administrative relief, tort reform, and the primary care physician shortage.

Universal Coverage

Under Governor Casey's health system reform proposal, virtually all Pennsylvanians would be guaranteed, and required to obtain, coverage of a defined benefit package. The universal coverage provisions do not apply to Medicare eligibles, federal employees and their families, and persons eligible for a limited religious exemption. The Society applauds the governor for taking the initiative to put forth a universal coverage proposal, and we especially support the decision to cover preventive care for pregnant women and children. However, the Society believes that individuals who can demonstrate financial responsibility for catastrophic care should not be required to purchase insurance coverage.

Scope

The proposal outlines a comprehensive package—but generally leaves the details to be articulated by the Health Security Board in a Health Security Plan. Individuals may buy supplemental coverage for more benefits and/or less cost-sharing. The guaranteed package must include all the currently mandated benefits and maternal and child health services. In addition, provisions in existing law that require coverage of limited license practitioner services apparently would continue.

We are concerned that the proposal allows the Health Security Board to adopt too broad of a guaranteed benefit package. A better starting point is the AMA/Society benefit package. While our package is also comprehensive, it does not cover all the services outlined in the governor's proposal and includes durational, cost, age, and other limits. The proposal inexplicably requires the board to incorporate all the current mandated benefits—irrespective of their value in relation to other services. While some of the current mandates—such as childhood immunizations—clearly should be in the final guaranteed benefit package, forcing inclusion of all the current mandates may result in the exclusion of services determined to be of higher value.

We question mandatory reimbursement of non-physician care. It unnecessarily limits legitimate efforts to control costs and maintain quality. The incentives for plans to keep premiums low are sufficient to assure coverage of non-physician care when it is truly more cost effective.

Patient cost-sharing

The guaranteed package would include uniform patient cost-sharing requirements. Individuals could not purchase catastrophic-only coverage with a high deductible (e.g., $1,000). We support patient cost-sharing as it is an effective way to control costs. We agree that the cost-sharing for primary care office visits and preventive care should be "minimal." Patients should not be discouraged from obtaining these services as they often can reduce costs in the long run and are important for maintaining patient wellness. We recognize that patient cost-sharing can be an insurmountable barrier to low-income persons and are concerned that the proposal does not explicitly authorize reduced cost-sharing or subsidies to help low-income persons pay these requirements. Individuals also should be able to purchase coverage with a full range of patient cost-sharing options—including catastrophic coverage only with a high deductible (e.g., $1,000)

24-hour coverage

The door is open for 24 hour coverage i.e., automobile and workers' compensation in the guaranteed benefit package. We generally support 24-hour coverage, but object to forcing auto accident victims and injured workers into a managed care system—as would result from inclusion of these services in the coverage guaranteed by the Casey proposal.

Health Security Board

A new quasi-public corporation called the Health Security Corporation (HSC) would oversee and administer the system with the Departments of Health and Insurance. The corporation would be governed by a nine-member Health Security Board.

Powers

The board has broad and largely unchecked powers. Many details are left to the board to develop in a Health Security Plan, and the board is exempt from having the plan and its regulations approved by the Independent Regulatory Review Commission (IRRC).

The proposal leaves far too many details to the discretion of the Health Security Board. While the legislature has the authority to modify or reject the Health Security Plan, the board's plan will nonetheless go into effect if the governor vetoes the legislature's action, and the legislature is not able to override the governor's veto with at least a two-third's vote in each chamber.

The required opportunities for public input on the Health Security Plan are inadequate. The proposal only requires public input through two sets of public hearings and written comments during a narrow 30-day window period. One set of the hearings are held and the written comments are due after the board has developed its plan—and the board appears to have no authority to make changes based upon the post-mortem input it receives.

We oppose the board's IRRC exemption because it eliminates an important forum to remedy arbitrary agency actions.

Composition

The board would be appointed by the governor and include: the Secretary of Health, the Secretary of Public Welfare, the Insurance Commissioner, and representatives of business (2; one small business), labor (1), consumers (1), individual providers (1), and health facilities (1).

The Society is concerned with the lack of physician representation on the board—especially given its authority and responsibilities regarding the defined benefit package, outcomes measurement, and practice parameters. While the law currently requires the Secretary of Health to be a physician, there are continuing attempts to remove that requirement, and the secretary's administrative duties preclude active clinical practice. In addition, the lone individual provider could be filled by a non-physician.

We are further concerned with the appointment process. No provision is made for nominations or other input from professional and other groups that are knowledgeable regarding persons who possess the necessary expertise. The net result is likely to be appointments highly influenced by political considerations—rather than primarily based on merit.

Clinical Advisory Council

A Clinical Advisory Council would advise the board on the specifications for the guaranteed benefits package, specifications of appropriate practice parameters, the study and efficiency of new and experimental procedures, and other clinical and miscellaneous matters at the request of the board.

The council would be chaired by the Secretary of Health and include at least nine other non-salaried private members appointed by the board, including two physicians (at least one primary care physician), a hospital representative, two mid-level health practitioners (at least one nurse), a health clinician, one biostatistician, a health economist, and a health researcher.

Our concerns with the board's composition would be lessened if the board was required to consult with appropriately composed technical advisory committees on clinical matters. However, instead, the board will be advised on these matters by a so-called Clinical Advisory Council that is clinical in name only.

The council can include only two physicians, and there is no requirement that the physicians be in active clinical practice—as opposed to being academicians, medical executives, or retired physicians, who often are not familiar, or up-to-date, with the day-to-day clinical and other problems encountered by actively practicing physicians. None of the non-physicians have the expertise to make judgments on clinical matters.

While the board is authorized to appoint other clinical advisory committees, there is no requirement for a provider technical advisory committee. Indeed, the board is instructed to use the Pennsylvania Health Care Cost Containment Council (PHC4) board as its interim data technical advisory committee. The PHC4 Technical Advisory Committee would have been a better choice.

Health Care Networks/ Regional Competition

The health care delivery and financing system would be radically restructured under the Casey plan.

Pennsylvanians, including Medicaid recipients, would be required to obtain their guaranteed coverage by enrolling in a health care network through the Health Security Corporation, which would act like a single statewide health purchasing cooperative. No provision is made for employer self-insured plans.

Although the required community rating obviates the need for small employers to join forces to better spread the risk and increase their bargaining power, health purchasing cooperatives may be useful in reducing network marketing and other administrative costs for small groups.

However, the radical restructuring of the health care financing and delivery systems envisioned by the Casey proposal is bureaucratic overkill. The problems of small employers can be resolved by permitting voluntary purchasing cooperatives—without forcing an additional, potentially expensive layer of bureaucracy on all employers.

Note: A federal waiver would be required to mandate Medicaid enrollment. Medicaid services not covered by the guaranteed benefit package—such as long-term care—would continue under the existing Medicaid system.

Regions

Health care networks would compete in regions that would be established by the Health Security Board, using the nine existing PHC4 regions as a starting point. Networks would be required to service the entire region. The requirement that networks service the entire region will unnecessarily restrict competition—especially if the Health Security Board adopts the PHC4, or equivalent sized, regions.

The PHC4 regions encompass multiple counties. Requiring networks to service such massive areas will limit the "competition" to monopolistic mega-networks. Small local networks will not be able to survive unless they are able to subcontract with a large regional network. The net result will be that providers and consumers will have little bargaining power when dealing with health care networks on important matters affecting access and quality.

In addition, the hierarchy of large networks will be too distant from the local community to appropriately respond and tailor programs to unique community needs.

Network selection

Individuals—not their employer or the state (in the case of Medicaid recipients)—would select the health care network of their choice from among those competing in their region. Allowing individuals to select the plan of their choice encourages competition and empowers individuals—rather than others such as employers, the government, and health care networks—to control their health care decisions. However, the proposal significantly cuts back on individual choice by not allowing individuals to select catastrophic-only coverage with a high deductible and mandating managed care.

Provider autonomy/network selection

Physicians and other providers could enroll in multiple health care networks. However, there is no "any willing provider requirement"—i.e., no safeguards would limit the grounds upon which health care networks could exclude physicians. →

One of the Society's major concerns with the Casey proposal is the lack of any safeguards to prevent the inappropriate exclusion of providers from health care networks and to otherwise assure that health care network efforts to control costs do not adversely affect quality.

Antitrust reform is also needed to provide a level playing field when physicians and other providers negotiate with networks. Otherwise a few monopolistic networks will dominate the market and have little incentive to compete for quality providers.

Employer Mandate/ Subsidies

The guaranteed coverage would be primarily financed by mandated employer contributions and employee premium-sharing. Subsidies would be provided to small employers, low-income persons (including Medicaid recipients), and the short-term unemployed. The details of these subsidies are left to be developed by the Health Security Board in the Health Security Plan.

In the short run, the Society supports expanding coverage by building on the current employer-based system. However, the long-run goal should be to shift to a consumer choice model, a system that provides for personal ownership of insurance with need-based subsidies for low-income persons. Consumer choice creates powerful market forces to control costs through heightened patient cost-consciousness, while preserving patient freedom of choice, minimizing bureaucracy, and more equitably distributing responsibility for financing expansion of coverage.

An employer mandate also necessitates requiring the Medicare and Medicaid programs to pay their fair share so that employers are not forced to pay for the underfunding of these programs through cost-shifting. Provision also needs to be made for portability of employer-arranged coverage.

Benchmark premium

A "benchmark premium" would be paid into the system for all eligible individuals, including low-income persons and the unemployed. The benchmark premium is the lowest rate in the region plus add-ons necessary to fund the small business subsidies, the Health Security Corporation's expenses, medical education and research payments, and deficits from inadequate appropriations for low-income subsidies.

The Health Security Board would set the lowest rate through a bidding process. Losing bidders could not subsequently lower their rate. Health care networks would be paid their full rate out of the benchmark premium payments and additional consumer contributions for higher cost plans—except that provision is made for risk-adjusted payments and networks would be required to accept the lowest rate in the region for low-income persons.

While the governor has promoted his proposal as not requiring new taxes, employers and employees are taxed thorough the add-ons incorporated in the benchmark premium. We are concerned about the fairness of this funding method. The add-ons would be a fixed amount per employee and would not vary by the income of the employer or employee unless they were entitled to low-income or small business subsidies. Employee unemployment payments also appear to be a fixed amount per employee. Funding the plan thorough the income tax system and "sin" taxes may be more equitable.

We also are concerned about the expense of the add-ons. There are no limits on the amount of these add-ons other than the cap on the administrative expenses of the Health Security Corporation (.01 percent of premiums). Only the administrative costs of the Health Security Board must be approved by the legislature as part of the budget process.

The governor has not provided estimates of the cost of the guaranteed benefit package or the add-ons. Indeed, these estimates cannot be adequately projected given the current lack of details regarding the actual contents of the guaranteed benefit package and the subsidy programs, and the lack of any meaningful caps on the add-ons.

Finally, we are concerned that the "tied to bid" rule may reduce competition. Not allowing networks to adjust to market conditions will result in some networks going out-of-business. These networks are not likely to be around for the next "competition."

Employer contributions/ employee premium-sharing

The mandated employer contribution generally is 90 percent of the "benchmark premium" for full-time employees and 45 percent for part-time employees (less than 20 hours per week or $85 per week). Employees generally would pay the "remainder" of the benchmark "premium" plus the difference between the rate charged by their network and the lowest rate in the region.

We support not requiring an employer to pay the full amount of an employee's premium. Employee premium-sharing helps control costs by making employees more cost conscious when they select their coverage.

Employee unemployment payments

Employees also would pay a premium surcharge to fund the unemployment subsidies. This is another unlimited tax on employees.

State funding

The administration assumes that the legislature will appropriate sufficient funds to fully fund the low-income subsidies so that a full benchmark premium is paid for all Medicaid and other low-income persons. However, the legislation does not provide for full funding of the low-income account through appropriations to Medicaid and other public programs.

We are gravely concerned, based upon past underfunding of the state Medicaid program, that the state will not adequately fund the low-income subsidies, thus perpetuating the cost-shifting in the current system. Indeed, the legislature may even be more inclined to underfund the account as a result of the built-in safety net provided by the add-ons.

In the event the state does not fully fund the low-income account, employers and employees would be required to pick up the difference. If the state appropriated only enough to pay the lowest rate in the region for all Medicaid recipients, employers and employees would essentially be required to fully fund the low-income subsidies for non-Medicaid recipients, the small business subsidies, the Health Security Board administrative expenses, and the medical education and research subsidies. If the state did not even appropriate enough to pay the lowest

rate in the region for all Medicaid recipients, employers, and employees would have to pay that deficit as well.

Mandated Managed Care

All health care networks would be required to be licensed as a health maintenance organization (HMO) and to provide each enrollee with a primary care physician who would serve as their gatekeeper. Enrollees generally would be required to use their gatekeeper for their primary care services.

In addition, absent purchase of a point-of-service option, enrollees generally would need prior approval from their gatekeeper for non-primary-care services and could not use an out-of-network provider.

We support a pluralistic insurance market in which consumers have the freedom to choose from a full range of coverage options—including an HMO or other managed care plan. However, we adamantly oppose mandated managed care because of the restrictions managed care plans impose on patient freedom of choice.

Some patients may voluntarily elect to enroll in an HMO or other managed care plan, especially if the premium is lower. However, others will prefer to enroll in an indemnity plan so that they can freely choose their physicians and make their own health care decisions, free of the dictates of a gatekeeper or their insurer.

Allowing individuals the freedom to select the health insurance plan of their choice also adds an important "safety valve." Network managed care systems will be more concerned about patient satisfaction with network providers if enrollees have the option to switch to an indemnity plan that would allow them to select the provider of their choice. Allowing indemnity plans also establishes a yardstick by which the cost-effectiveness of network managed care plans can be judged.

Indemnity plans—especially "pure" indemnity plans with no managed care—may have difficulty competing in an environment with heightened cost-consciousness. However, why not let the market forces work? Those indemnity plans that cannot effectively compete will not be selected by patients or offered by insurers. Moreover, allowing indemnity plans as an option will not increase the expenditures of employers or other sponsors.

We also question how a mandatory gatekeeper system can be implemented without adversely affecting quality and access—given our state's primary care physician shortage. While multiple efforts are underway to resolve the shortage, more needs to be done. In any event, the shortage is likely to continue until well into the twentieth century—even if all the necessary remedial measures begin now.

Eligible gatekeepers

Gatekeepers generally would be primary care physicians. A health care network would be permitted to designate a specialist physician as the gatekeeper for a chronically ill enrollee when the substitution would provide the enrollee with the most cost-effective care. Female enrollees could use a network gynecologist for their annual routine gynecological care without prior approval from a gatekeeper. We are pleased that the legislation appears to limit the eligible gatekeepers to physicians and would not permit a health care network to require an enrollee to go through a limited license practitioner to see a physician.

Note: While the legislation does not define "primary care physician," many HMOs define them as general and family physicians, general internists, and pediatricians.

We are concerned about the exclusion of obstetrician-gynecologists (ob-gyns) as eligible gatekeepers. Ob-gyns provide the only medical services received by many women—particularly women in their reproductive and menopausal years. All ob-gyns, even those that limit their practices to female reproductive and gynecological services, play an especially important role in early detection care and health education for women. They also provide care that is longitudinal and frequently maintain a woman's medical record for much of her life.

Reimbursement incentives

Health care networks would be required to incorporate "reasonable financial incentives to promote quality health care and contain costs" in the reimbursement arrangements for their network providers. We are opposed to this requirement. Many individuals prefer to make their own health care decisions in consultation with a physician who is not being provided financial incentives to limit their care—even if they must pay a higher premium to obtain unbiased advice. Moreover, inappropriate utilization can be controlled through a variety of alternative mechanisms such as utilization review, provider credentialing, and patient cost-sharing.

We are also concerned that similar language has been used by the Department of Health to require HMOs to pay gatekeepers only on a capitation basis. Again, fee-for-service payments combined with a bonus or holdback plan also can deter inappropriate utilization and should be an option.

Point-of-service option

Health care networks would be required to offer a "point-of-service" option that would allow enrollees to bypass their gatekeeper for specialty and other non-primary-care services from any network or out-of-network provider. Point-of-service options would be required to monitor the care provided under the option by precertification, utilization review, and managed care techniques approved by the Department of Health.

We support the requirement that health care networks be required to offer a point-of-service option. However, this option is not the equivalent of allowing patients to select indemnity or similar coverage that allows them free choice of provider.

Patients will still be required to use their gatekeeper for primary care services and will need to pay higher cost-sharing for using an out-of-network provider. In the addition, the costs of the point-of-service option's compliance with HMO regulatory requirements will be reflected in the premiums and could force them higher than those that would be charged by a true indemnity plan (not subjected to HMO-type regulation.)

The Society also objects to the mandated utilization review. Individuals should be free to select coverage without precertification requirements. Moreover, utilization review is only one of a number of ways that plans can effectively control utilization.

REFORM LEGISLATION EXPECTED TO PASS IN 1994

In a recent meeting with State Society leaders, policy staff members of the Casey administration said they are anticipating the passage of health system reform legislation in 1994. Discussion at the meeting focused on several key aspects of the Casey reform proposal.

The Casey staff clearly indicated that the administration would be willing to consider revisions to some sections of the proposed reform legislation, and they advised that it was not the intention of the administration to exclude a fee-for-service option. Since the governor's return to office, the momentum and push for his proposal have been heightened.

Other Society legislative efforts related to reform focus on self referral, equal access/mandatory participation, optometry therapeutic licensure, and scope of practice issues. The Society is particularly concerned about one measure, included in a series of rural health bills developed by Senator John Peterson (R-Venango), which would expand the nursing scope of practice to include prescriptive privileges.

For more detailed information on legislative issues related to health system reform, see page 20.

Health Care Summit Group

In related news, the Society continues to participate in a Health Care Summit Group of the Pennsylvania Business Roundtable, comprised of representatives of state health, insurance, and business organizations.

The group has developed a consensus document outlining general areas of agreement on health system reform, as well as delivery system, financing system, cost containment, and quality of care issues. The document was presented during testimony before House and Senate committees researching the reform issue.

AMA LAUNCHES CAMPAIGN TO PROTECT PATIENT CARE

The AMA on January 24 called on Congress to pass a health system reform bill that assures every American of universal coverage for a standard set of benefits, regardless of employment or economic status. As a centerpiece of this proposal, the AMA is launching a national grassroots campaign to urge Congress to protect patients and their doctors from the increasing domination of America's health care system by giant profit-seeking corporations.

AMA priorities include:

- universal health care coverage for every American;
- assuring that physicians, as advocates for their patients, play a significant role in deciding how health care is delivered and paid for;
- guarantees that all patients have a choice of health plans and physicians;
- medical liability reforms modeled after California's successful system;
- relief from antitrust laws that prohibit physicians from negotiating quality of care and conditions of patient coverage with insurance and hospital plans; and
- creation of a new public/private partnership to set and monitor national quality of care standards.

The AMA also repeated its support for a variety of approaches to universal health care coverage, including employer-required coverage, individually required and owned health insurance, and IRA-type medical savings accounts.

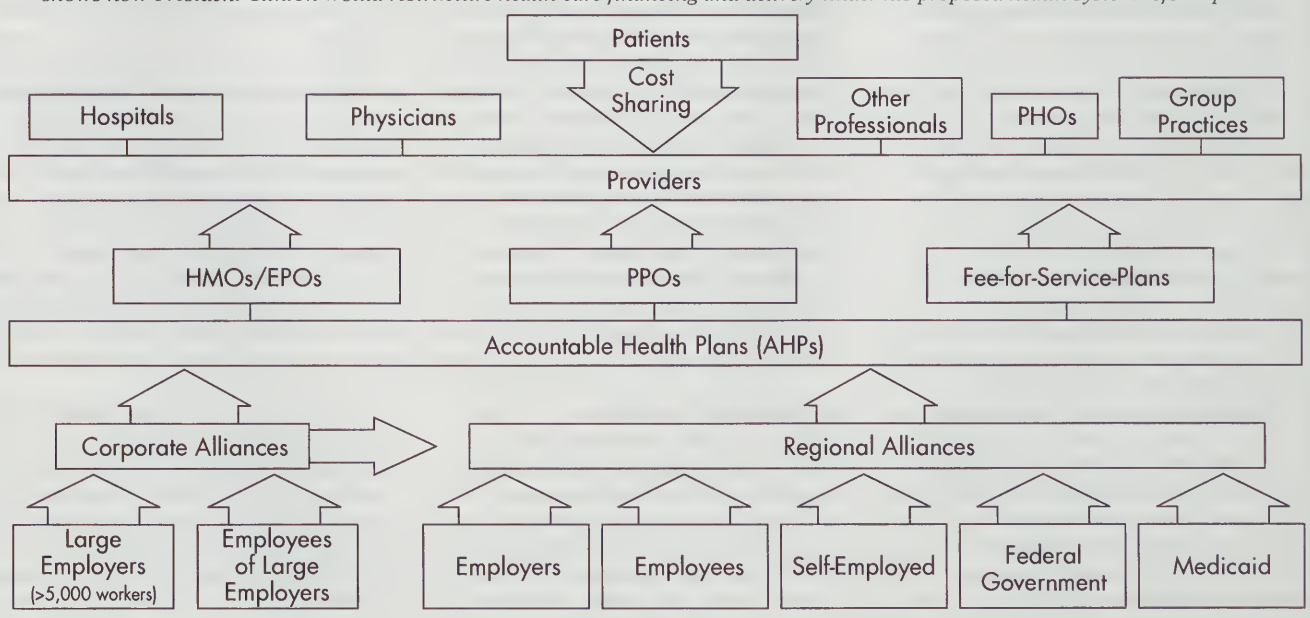
Call to Action

The State Society, in response to the AMA's patient care campaign, is encouraging doctors to: talk with their patients about health system reform, organize local forums on reform, contact their local media, and visit congressional representatives in their home districts.

To help you, the society has prepared talking point cards, brochures, and other materials. Call the communications division at (800) 228-7823 for details.

Health Care Financing and Delivery Under the Clinton Plan

This chart—developed by the Pennsylvania Medical Society as part of its response to the proposed Health Security Act—shows how President Clinton would restructure health care financing and delivery under his proposed health system reform plan.



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ACTIONS OF THE BOARD OF TRUSTEES, JANUARY 12, 1994

CONTACT WITH MEMBERSHIP IS NEW PROJECT'S GOAL

To enhance the State Society's visibility with grassroots members, the Board of Trustees at its January 12 meeting authorized a Society staff position "out in the field" as part of a five-year pilot project to be conducted in an area of the commonwealth with a high-density physician population. The new "membership representative" will visit physicians in their offices to address issues of interest to them.

The recommendation came from the Society's Task Force to Enhance Physician Involvement, formed early in 1993 to study the changing needs of Society members and the root causes for lack of physician participation in organized medicine. According to a task force report to the board, "While still in the early stages of deliberation, the task force has been convinced that one of the major problems the State Society has is a lack of visibility with rank and file physicians."

Though other state medical societies have field representatives to monitor the environment of medicine and listen to member concerns, the task force says the objective of the new position is similar to that of pharmaceutical firm representatives who are in constant contact with physicians in their sales areas. The membership representative would work at Society headquarters on an as-needed basis—to follow-up on field activities and attend key Society meetings—but would spend the majority of time meeting with current and prospective members.

This is the first in a series of recommendations to enhance member involvement expected this year from the task force. The Society is planning to fill the position within the next several weeks.

START-UP OF FOR-PROFIT SUBSIDIARY MOVING QUICKLY

The Society's project to develop managed care services and consultation capabilities continues to move on a fast track.

Initially, the for-profit subsidiary will include two primary components—a physician services component and a management services organization (MSO) component. One of the first responsibilities of the steering committee, appointed in October to guide the development and start-up of the Society's subsidiary, will be to determine which physician services currently provided through the Society's Council on Medical Practice should be transferred to the subsidiary. Also, the Society is working with KPMG Peat Marwick to develop a formal business plan for the MSO.

The Society will begin—through the MSO—to provide: technical assistance for physician network formation and managed care contracting; clinical protocols and outcomes measurement tools; and practice management services, including billing/collection services and group purchasing. Meanwhile, consulting services are available to physicians interested in network formation through the Society's consulting company.

The Society is currently researching potential governance structures for the for-profit subsidiary, developing a draft mission statement, and preparing draft corporate bylaws for steering committee review. The board is expected to consider further action at its meeting this month.

PROGRAM WILL EASE IMG LICENSURE OBSTACLES

At the recommendation of the Council on International Medical Graduates (IMGs), the board approved the establishment of an ombudsman program to assist Society member IMGs who encounter difficulties in obtaining a medical license in Pennsylvania. Informally, the Society's liaison with the State Board of Medicine has performed this function for several years.

The committee reported that it received correspondence from several IMGs who have had problems getting their licenses. For instance, delays often occur when applicants don't understand the requirements or options available to resolve deficiencies noted by the State Board. The committee believes other IMGs have faced similar problems but have not reported them.

Through the ombudsman program, the Society will continue to: 1) help member IMGs determine what documentation is needed or could be added to expedite the licensure process; and 2) act as a liaison for member IMGs experiencing difficulty in dealing with the State Board. The Society will also help nonmember IMGs who apply for membership.

For additional information about the ombudsman program, call the Society's Department of Education and Science at (800) 228-7823 or (717) 558-7750.

OTHER ACTIONS OF THE BOARD

In other action at its January meeting, the board:

- directed the Society to write a letter to Secretary of Health Allan S. Noonan, MD, expressing concern about some specifics of the Pennsylvania Department of Health's "Guidelines for Preventing the Transmission of Human Immunodeficiency Virus and Hepatitis B Virus from Infected Health Care Workers to Patients," released in October 1993;
- approved the recommendation of the Council on Medical

New Procedure Credentialing Protocol Approved for HMSS Use

In response to the efforts of the Society's Hospital Medical Staff Section (HMSS) Governing Council, the board approved "New Procedure Credentialing Protocol" for Pennsylvania hospital medical staff use. The document, mailed to HMSS representatives and medical staff presidents of unrepresented hospitals in late January, defines "new procedure" and suggests criteria for credentialing a new procedure. For more information, or to receive a free copy of the document, call the Society's Department of Medical Staff Relations at (800) 228-7823 or (717) 558-7750.

Economics that the Society establish a Pennsylvania Relative Value Update Committee to provide Pennsylvania Blue Shield with physician input into the development of relative value units (RVUs) for various Blue Shield networks which use a relative value scale (e.g., PremierBlue); and

• agreed to support the recommendation of the Joint Data Committee of the Society, the Hospital Association of Pennsylvania, and the Pennsylvania Osteopathic Medical Association that the next Pennsylvania Health Care Cost Containment Council (PHC4) physician-specific report be on acute myocardial infarction.

CORRECTION

In *Annual Meeting* coverage of the December issue of PENNSYLVANIA MEDICINE (page 20), a portion of the Society's self-referral policy was incorrectly reported. The correct language is:

*Physicians should not refer patients to off-site facilities in which the physicians have an investment interest unless: 1) they **directly** provide care or services in the facility; or 2) there is a demonstrated community need for the facility, and alternative financing is not available.*

How To Get Involved in 1994 Election Campaigns

Political participation is both a freedom guaranteed by the laws of our nation and state, and an incredibly effective means of guaranteeing that your views will be heard when your successful candidate is elected to office. The 1994 elections offer a tremendous opportunity for physicians and their spouses to get involved in a campaign—as a financial contributor or as a campaign worker. You are especially encouraged to consider "getting involved" in a statewide campaign of a candidate for governor or U.S. Senator. Below is a current list of candidates for governor and U.S. Senate, along with a short biography of each and how to contact their campaign offices or physicians already involved in the campaign. For additional information about what role you can play in this year's elections, call the Society's Division of Governmental Affairs at (800) 228-7823 or (717) 558-7750.

CANDIDATES FOR GOVERNOR

Dwight Evans (D)
Serving fourth term in the state House; represents 203rd District, Northwest Philadelphia; priority issues have included child care and child welfare. *Contact:* Friends of Dwight Evans, P.O. Box 19097, Philadelphia 19138, (215) 548-8054.

Mike Fisher (R)
Serving fourth term in the state Senate; represents 37th District, including Pittsburgh's South Hills and part of Washington County; former member of the House of Representatives. *Contact:* Fisher '94 Committee, 12th Floor, Two Chatham Center, Pittsburgh 15219-9795, (412) 288-2227; or Robert Carroll, MD, at (412) 367-1188.

Sam Katz (R)
Independent businessman and fiscal expert; former member of Philadelphia Board of Education; sought 1991 Republican nomination for mayor of Philadelphia; proposes to reduce the size and cost of government. *Contact:* Friends of Sam Katz Committee, One Penn Center, Suite 1360, 1617 JFK Boulevard, Philadelphia 19103, (215) 569-1994; or Robert Sataloff, MD, (215) 545-3322.

Robert O'Donnell (D)
Former speaker of the state House; represented 198th District, Northwest Philadelphia, since 1974; priority issues include creating jobs, improving schools, and combatting crime. *Contact:* O'Donnell for Governor Committee, 1617 JFK Boulevard, Suite 1930A, Philadelphia 19103, (215) 567-3341.

Ernie Preate Jr.(R)
Serving second term as attorney general; worked to enact new drug laws, expand local municipal drug task forces, develop better consumer laws, and reform lobbying laws; veteran. *Contact:* Ernie Preate for Governor Committee, 128 Walnut Street, Harrisburg 17101, (717) 234-1994.

Tom Ridge (R)
Serving fifth term in Congress; represents 21st Congressional District; campaign focusing on making Pennsylvania "job friendly," restoring the state's business climate; veteran. *Contact:* Tom Ridge for Governor Committee, P.O. Box 11667, Harrisburg 17108, (717) 231-1632; or Charles D. Hummer Jr., MD, (610) 876-0347.

Mark Singel (D)
Serving second term as lieutenant governor; former state senator representing 35th District, including Cambria and Clearfield counties. *Contact:* Friends of Mark Singel Committee, P.O. Box 11624, Harrisburg 17109, (717) 238-1995; or Victor F. Greco, MD, (717) 788-3225.

Charles Volpe (D)
Attorney and insurance executive; son of late Representative Charles J. Volpe Sr.; active in workers' compensation reform; strong advocate for stricter sentencing guidelines involving violent juvenile crime. *Contact:* Volpe for Governor Committee, P.O. Box 9663, Pittsburgh 15226, (412) 344-8683.

Lynn Yeakel (D)
Won Democratic primary in 1992 for U.S. Senate seat, but lost in close race against incument Republican Arlen Specter; has shown interest in public health issues. *Contact:* Lynn Yeakel for Governor Committee, 1617 JFK Boulevard, Suite 1665, Philadelphia 19103, (215) 557-2500.

*State Treasurer **Catherine Baker Knoll** at one time said she would not run for governor, but just prior to press time, she announced her candidacy. Keep an eye out for further details.*

CANDIDATES FOR U.S. SENATE

Rick Santorum (R)
Serving second term in Congress; represents 18st Congressional District, campaign focusing on health care, welfare reform, and budgetary issues. *Contact:* Santorum '94 Committee, 340 East Main Street, Carnegie 15106, (412) 882-3205; or Robert Carroll, MD, at (412) 367-1188.

Harris Wofford (D)
Elected to Senate in 1991 special election to replace the late Senator John Heinz; reelected in 1992 on health system reform platform. *Contact:* Citizens for Senator Wofford, 1420 Walnut Street, Suite 808, Philadelphia 19102, (215) 731-1944.

Sources:
1. Corrinne J. Who's running. Bus Rpt, *January 1994, pp. 5-8.*
2. Davenport D. "Here's a look at crowded gubernatorial field for May 10 primary." Patriot News, *January 30, 1994, p. B-9.*

MEDICAL LIABILITY REMAINS VITAL IN REFORM DEBATE

Medical liability reform continues to be an issue of discussion whenever health system reform is debated. As a result, a number of legislative proposals addressing medical liability reform have been introduced in both the Pennsylvania Senate and House of Representatives:

- Senate Bill 1199—Senator Hardy Williams (D-Philadelphia) introduced this arbitration panel bill as part of the governor's five-bill reform package.
- Senate Bill 1173—Senator D. Michael Fisher (R-Allegheny) introduced this comprehensive bill, which contains several measures outlined in the Society's health system reform proposal, such as defining the terms "informed consent" and "expert," determining a statute of limitations, and allowing punitive damages only for "outrageous conduct with evil motive."
- House Bills, 563, 1495, and 1496—Representative Leo Trich (D-Washington) introduced this series of bills. House Bill 563 establishes a practice parameter system, based on the existing law in Maine; House Bill 1495 calls for periodic payments of awards; and House Bill 1496 seeks to limit non-economic losses.
- House Bill 1529—Representative Al Masland (R-Cumberland) introduced this measure that would limit attorney contingent fees.
- Senate Bill 1026—Senator William Stewart (D-Cambria) introduced this bill to limit damage awards.
- Senate Bill 1034—Senator Michael Dawida (D-Allegheny) introduced this bill, also to limit punitive damage awards.

To date, these bills have failed to receive any committee consideration. However, provisions contained within these measures may be considered as potential components of any forthcoming health system reform proposals.

Society lobbyists have led efforts to derail two bills that would have placed a financial assessment on health care "providers" to pay for reconciliation panels set up by the courts in 36 counties. The first measure, House Bill 1959, was defeated by the House Insurance Committee by a 10-7 margin. A comparable bill, Senate Bill 1016, was defeated twice by the full Senate in June 1993.

Although the language found in House Bill 1959 allowed for fees to be established after enactment, Senate Bill 1016 mandated that the fees would be identical to those that had been suspended when the panels were operating with surplus funds—for example, $25 for physicians and podiatrists, and as much as $500 per hospital.

Recognizing these bills are directly related to the budget process, it is very likely that they will receive consideration early this year. The Society continues to oppose these bills.

Society staff continue to meet with key legislators and representatives from business, insurance, and the health care industry, to discuss the Society's position on medical liability reform and its importance in the health system reform debate.

SENATOR PROMISES ACTION ON HEALTH SYSTEM REFORM

Senator Hardy Williams (D-Philadelphia), in a news conference early this year, announced what he called "a new year's resolution of promised action" on health system reform in Pennsylvania. He said he intends to report out for final Senate action a series of health care "infrastructure" bills and an "HMO any willing provider" bill.

According to the senator, the bills will include provisions to: create an Office of Health Insurance Consumer Advocate; develop incentives for physicians to enter family practice as a specialty; broaden the scope of services performed by nurses, physician assistants, and certified nurse midwives; establish statutory practice parameters for physicians and other practitioners; and organize tighter security surrounding medical records to protect computerized medical histories.

Senator Williams expected to move the bills out of the Senate Public Health and Welfare Committee early last month for consideration of the full Senate this month. At press time, the Society was reviewing all of the legislation and preparing to have amendments offered that are consistent with Society policy.

In related news, the Society participated in a February 23 debate on tort reform coordinated by Senator Williams. The senator is also sponsoring a series of health system reform "summits" in each of the eight regions of Pennsylvania identified in the governor's reform proposal. The summits will continue through June.

For more information on Society efforts related to health system reform, see page 16.

REGISTER NOW!

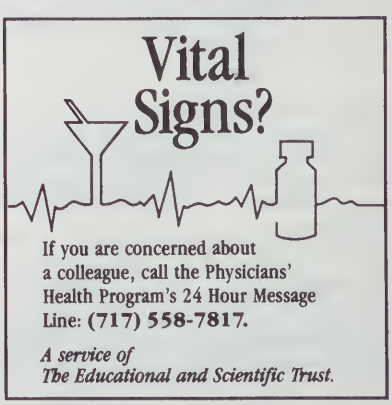
APRIL SEMINAR TO DISCUSS SKILLS TO IMPACT ELECTION

Among several events scheduled in conjunction with the Society's 1994 Spring Assembly is "Practicing Politics," a full-day seminar on April 18 at the Harrisburg Hilton and Towers.

Nationally recognized speaker Michael Dunn will present "political skills you need to have an impact on the 1994 election." Sponsored by the American Medical Political Action Committee (AMPAC) and the Pennsylvania Medical Political Action Committee (PAMPAC), the seminar will also include a legislative issues briefing and personal visits with state legislators at the Capitol.

The seminar is open to all State Society and Alliance members. A $15 fee is being charged to cover the cost of lunch. For more information or to register, call the PAMPAC office at (717) 558-7822 or the State Society at (800) 228-7823. *Register now—space is limited.*

Also, for more information about the Society's Spring Assembly, see pages 42-43.



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3:30-4:00	Old and new drugs in treating serious rhythm problems	*Mark W. Preminger, M.D.*
4:00-5:00	Case Presentation	*Jeffrey G. Kegel, M.D.*
	Panel Discussion *David J. Callans, M.D.*	*Joel Morganroth, M.D.*
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Vice Speaker Considers Realities of '90s Medicine

Maria T. Montesano
Assistant Managing Editor

Next month: Look for a profile of newly elected young physician trustee John R. Martell Jr., MD.

This first in a series of interviews with Society board members newly elected at the annual business meeting in October profiles Donald H. Smith, MD, vice speaker of the State Society's House of Delegates.

Dr. Smith

His face and voice are sure to be familiar to members of the State Society's House of Delegates—he's had a reserved seat with the Northampton County delegation since the early 1980s. He's faced the delegates many times, voicing what he believes is best for patients, physicians, and medicine. Seeing him in action, you couldn't call him shy. But this year his role will change. This year Donald H. Smith, MD, will have a new seat at the annual meeting—on the stage, facing the same House that elected him its vice speaker last October.

Dr. Smith is what you might call a born leader. He graduated at the top of his Williamsport High School class and was involved in several leadership activities. Though a run for president of his undergraduate class at Lehigh University was unsuccessful, he continued to lead activities for his fraternity and participate in athletics throughout college. But, he says, by the time he got to medical school, he was married and raising three children, and he wasn't involved at all. "That spilled over into my first several years of practice," Dr. Smith says.

Medical school was at Jefferson Medical College, a decision that made his father very happy. "My father was a Jefferson graduate," Dr. Smith says, "and it pleased him very, very much that I would follow in his footsteps." (For the record, J. Stanley Smith, MD, a dermatologist, served his county society well, including as president.)

Dr. Smith completed his internship and residency in general surgery at Lankenau Hospital, and has held his position in the Department of General and Oncological Surgery at Easton Hospital since 1970. He also serves as a consultant to St. Luke's Hospital, Bethlehem, and as an assistant clinical professor of surgery at Hahnemann Medical School, Philadelphia.

He joined the State Society in June 1970, but his involvement was gradual. His first effort on behalf of state physicians was in the mid-70s when he was asked to testify in Philadelphia at combined hearings of the House Judiciary and Health Insurance committees on medical liability insurance.

Dr. Smith says, "At about the same time, I got very upset with the reimbursement mechanism. I felt the payments physicians were receiving were inequitable, and the method of paying physicians was unfair. So, I wrote a letter to the Society and asked if I could be appointed to the council that dealt with this." He was appointed to the Council on Medical Economics in 1977 and served for six years. His involvement was recognized at the county level, and by 1979 he found himself president of the Northampton County Medical Society. He says, "I've been involved in various levels of medical politics ever since."

At the State Society, he has served as a member of the Council on Education and Science, and the Public Relations and Long-Range Assessment committees, and he has held leadership positions at the Pennsylvania Medical Society Liability Insurance Company and the Keystone Peer Review Organization. He currently is a member of the Society's Task Force on Health System Reform and has been involved with the Pennsylvania Delegation to the AMA since 1985, most recently serving as vice chair.

But his main interest is the House of Delegates. "From my first House meeting, I've enjoyed the responsibility and workings of the House, and I've become good friends with the House leadership," Dr. Smith says. His work chairing three reference committees and as a member of the

House's Credentials Committee has honed his interest.

"The House leaders were kind enough to ask me to chair several of the reference committees, and I became interested in the House actions. I was constantly trying to get some minor changes made to expedite the business of the House; some of my new ideas and thoughts were accepted and some were not, [and] I guess it was after being there for several years that I became interested in joining the leadership of the House. It seemed almost like a natural extension of my activities to try to be a leader of the House rather than just one of the participants."

Another responsibility of vice speaker is as a voting member of the Society's Board of Trustees. Although he says being a board member "has not been a major goal," he admits an interest in making some changes and representing the House at the board level. "There may certainly be times when issues arise where I personally don't agree with the House action," he says, "but it's my duty, along with the speaker of the house [Howard A. Richter, MD], to represent the delegates and their decisions. I think we both take that duty very seriously."

Serving as patient advocate is another duty for all members of organized medicine, according to Dr. Smith. Of the State Society and the AMA he says, "An organization of physicians is a bit unusual, because many of the responsibilities that physicians take on are not necessarily self-serving, in spite of what outsiders believe. The truth of the matter is that much of our work is done on behalf of our patients, and we take our responsibilities as advocates very seriously."

On the issue of health system reform, for instance, he believes the Society and the AMA must first certify that they are "organizations that really understand the issues and are prepared to offer decent and reasonable options." He says, "If you have the credibility, the individuals who want to know your particular perspective should come to you, rather than you forcing it down their throats. As you well know, in health system reform there has been a great deal of exclusion of the medical profession. I believe that exclusion is occurring because the policy makers don't think we are patient advocates. Instead, they think we are a self-serving, socioeconomic, lobbying group. Until we are perceived as something other than that, we're going to have a significant problem participating in the debate at a sensible level."

He says any position defending the rights of physicians for their socioeconomic welfare "must be secondary to the altruistic efforts that we want to make in true health system reform—that is, providing quality care to all the people and not having them excluded or by-passed in the system."

He believes the current American health care system has many good points and says, "To simply scrap all the good things about the system because there are some bad things is wrong." Instead, he believes reform efforts should focus on the "broken" aspects of the current system, such as access issues, unnecessary administrative burdens, medical liability (tort) problems, and tax law inequalities.

Though he is passionate about all four issues, he is most concerned about tort reform: "I said years ago, before health system reform was proposed, that there would eventually be a negotiation between the federal government and physicians in which they would trade a meaningful tort reform package for something that the doctors wanted. But now it looks like it's going to be a negotiation with the government offering reasonable and, perhaps, rather comprehensive tort reform for us in return for our acceptance of a health system reform package that we may not like. On that issue, we'll have to sit down, look at the details, and decide if we're willing to give up certain things for that kind of reform."

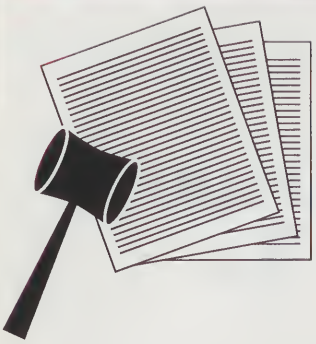
Overall, he advocates "individual mandate," where individuals would be mandated to have insurance: "They could buy it themselves, negotiate it as an employee benefit, or negotiate some combination of the two." Further, the poor and the indigent would be provided with a voucher system which, he says, would help the access problem, as well as control overutilization of services.

The health system reform debate includes many examples of how the problems of medicine are becoming more socioeconomic, according to Dr. Smith. "When I first became involved in the Society, we addressed the issues of professionalism and utilization and quality assurance. Today those things seem to be secondary to socioeconomic issues. We're all trying to make some reasonable suggestions on those issues, but I think in time we'll get back to the other, non-socioeconomic issues."

For instance, he believes that once organized medicine gets past health system reform, its next major obstacle to hurdle will be quality—how to define it and how to maintain it. He quickly adds, "It's important to get back to those issues." ⬡

"To simply scrap all the good things about the [health] system because there are some bad things is wrong."

—Donald H. Smith, MD



STATE SOCIETY SUPPORTS YOUR INTERESTS IN COURT

Legal Cases, 1983-93, Summarized for Members

From time to time, the State Society's Office of General Counsel has been asked about the Society's litigation history, such as what cases the Society has undertaken in the past and what issues have been involved. In August 1993, the Society's Board of Trustees asked the office to provide a study of the Society's litigation program over the past 10 years. The completed report was presented to the board at its January 1994 meeting.

At the request of the board, the results of the study are presented below to educate members about the Society's litigation program. Most members may not be aware of the Society's degree of involvement in the types of issues important to the practice of medicine in Pennsylvania.

The descriptive information following the case name includes whether the case is or was original litigation—that is, filed by the Society against another party—or an *amicus* case. The Society acts as an *amicus curiae,* or "friend of the court," when it is involved to educate the court about a particular point of law of great importance to the practice of medicine.

The descriptive information below also shows the time period in which the case was active, the issue involved, and the outcome of the case. The Society has dedicated more than $250,000 to litigation of these cases.

For further information, contact Susan M. Weber, Esquire, assistant general counsel, at Society headquarters.

Key
Case Name *(Asterisk indicates PMSLIC financial support)*
(Amicus or Litigation/Time Period)
Issue. *Case Outcome.*

Product Liability/Breast Implant Litigation*
(Amicus/July 1993-)
Should strict product liability allegations against physicians be allowed to go forward in over 200 lawsuits filed in Pennsylvania with respect to side effects caused by silicone breast implants? *Issue decided in favor of physicians, but appeal of issue in abeyance while awaiting court reconsideration of other issues.*

Boettcher v. King* *(Amicus/April 1993-)*
Who, if anyone, is liable for payment of post-judgment interest in CAT Fund case? *Pending.*

Pennsylvania Radiological Society v. Blue Shield
(Amicus/April 1993-)
1) Must HCFA pay an increased amount to certain physician specialists who were grossly underpaid for Medicare claims between 1984-86 when their compensation arrangements changed? Blue Shield, Medigap insurer, refused to pay, citing statute of limitations as a bar.
2) Must physicians file claims individually in order to receive payment, or is Blue Shield required to automatically pay them? *Pending—State Society waiting for appropriate time to file amicus brief.*

Beaver County Tax Appeal
(Litigation/March 1993-February 1994)
County society applied for a Section 501(c)(6) federal tax exemption and was denied on grounds its physician referral service is an impermissible activity for a tax-exempt organization. *Won—Federal tax exemption granted February 7, 1994.*

In re: Daniel Joseph Fiori *(Amicus/March 1993-)*
Discontinuance by a surrogate of life-sustaining medical treatment (artificial nutrition and hydration) of a patient in a persistent vegetative state without hope of recovery when the patient had no advance directive. *Pending—Brief filed May 1993; Superior Court remanded case for determination of patient's best interests, based on clear and convincing evidence standard. Reconsideration en banc granted. Awaiting hearing.*

Singer v. Player *(Amicus/March 1993-)*
Level of protection given mandatory reporting of child abuse. Amicus brief of State Society et al. supported neither party; supported immunity from liability for mandated reporters of suspected child abuse. *Superior Court ruled (in part) against mandated reporting on technical grounds.*

Hankinson v. Torrance State Hospital
(Amicus/October 1992-February 1993)
Discoverability and protection of peer review documents. *Protection from discoverability was waived in this case by actions of those seeking protection.*

In re: Application of Milton Hershey Medical Center of The Pennsylvania State University, and In re: Application of Harrisburg Hospital v. John Doe, MD
(Amicus/September 1992-November 1993)
Notification of patients of physician's HIV-positive status. *Lost—Pennsylvania Supreme Court held that hospital had met its burden of demonstrating compelling need to disclose status.*

Wu v. Spence* *(Amicus/September 1992-)*
Informed consent—Trial Court and Superior Court declined to expand informed consent requirement beyond surgical procedures to administration of drugs. *Pending—Awaiting Pennsylvania Supreme Court grant or denial of allocatur; amicus brief will be filed at appropriate time after allocatur is granted.*

Pennsylvania Bar Association v. Commonwealth of PA
(Amicus, not filed/May 1992-December 1992)
Chapter 18 of Act 6—violation of insureds' procedural and substantive due process rights. *Won—In late 1992, Pennsylvania legislature passed omnibus bill amending and repealing disputed statute sections.*

State Society v. Snider *(Litigation/March 1992-)*
Whether reimbursement policy violates physicians' rights to reimbursement under the Medicare Fee Schedule for treating Medicare patients. *Pending—State Society has appealed District Court opinion to 3rd Circuit Court of Appeals. Resolution expected in Spring 1994.*

Wolgemuth and Henry, et al. v.
Hershey Medical Center and Harrisburg Hospital
(Amicus/February 1992-)
Trial Court's opinion is that hospitals have a duty to patients to inform them of a resident physician's HIV status.

Pending—Court denied class certification. Decision appealed by plaintiffs.

Nazay v. Miller, et al.
(Amicus/September 1991-December 1992)
Dispute between employer and employee over ERISA payment of medical benefits. *State Society decided against filing an amicus brief, estimating likelihood of success to be very poor.*

Samuel S. Lyness, MD, v. Commonwealth of PA
(Amicus/November 1990-April 1992)
Does the admitted commingling of prosecutorial and judicial functions in the multi-member State Board of Medicine violate due process standards? *Won.*

State Society, AMA, et al. vs. Casey, State Board of Medicine, et al. (MOM case)
(Litigation/July 1990-December 1991)
Can a state enact a law which conflicts with federal law? (Re: House Bill 700 (Act 90-81)—Balance billing prohibition). *Lost.*

Stenger v. Lehigh Valley Hospital Center*
(Amicus/July 1990-June 1992)
Pennsylvania Supreme Court affirmed Superior Court's decision to subject volunteer blood donors to "anonymous" discovery in negligent screening suits. *Partial win, partial loss.*

Levine v. Rosen* *(Amicus/July 1990-December 1992)*
Malpractice case—Whether Superior Court panel erred in reversing Trial Court's accurate supplemental instruction to the irrelevant considerations charge that disclosed the malpractice payment reporting requirement of federal law. *Lost.*

State Society v. Foster
(Litigation/February 1990-April 1993)
Do billing prohibitions of the cost containment provisions of the Auto Insurance Act amendments violate physicians' due process rights? Is Insurance Department's interpretation of Act 6 with respect to application of the 110 percent of Medicare limitation on fees inconsistent with the language of the Act and intent of the legislature? *Lost—In April 1993, State Society Board of Trustees decided not to appeal Court's decision.*

DiMarco v. Lynch Homes, et al.
(Amicus/January 1990-January 1991)
Medical malpractice—Whether a physician is liable to a third party where physician failed to properly advise patient exposed to communicable disease and patient, relying upon physician's advice, spread disease to third party. *Lost.*

Gouse v. Cassell* *(Amicus/January 1990-December 1992)*
Medical malpractice—Whether a physician can be held liable for lack of informed consent even when patient would have consented to the procedure had the omitted information been provided. *Lost.*

Jyotindra T. Shah, MD, v. State Board of Medicine
(Amicus/December 1989-April 1992)
Due process—Doctor's temporary suspension by State Board of Medicine was imposed under procedures and circumstances violating due process. *Won.*

Tominello v. Janeway*
(Amicus/September 1989-January 1991)
Whether a medical malpractice plaintiff may enforce against a defendant physician the portion of a judgment covered by the CAT Fund. *Won.*

Doe v. Dyer-Goode *(Amicus/May 1989-November 1990)*
Unauthorized HIV testing of patient's blood by physician. *Won.*

State Society v. Pennsylvania Insurance Department and CAT Fund
(Litigation/December 1988-February 1989)
CAT Fund surcharge premium determination in violation of Section 701(e)(1) of the Health Care Services Malpractice Act. *Won.*

Hatter v. Landsberg*
(Amicus/September 1988-August 1989)
Physician's immunity against wrongful birth actions—construction of legislature's intent of statute. *Won.*

Makara v. Peguero*
(Amicus/September 1988-March 1989)
Whether a defendant physician can be compelled by a plaintiff to provide expert testimony. *Lost—State Society was denied permission to appeal.*

Commonwealth of PA v. Lurie
(Amicus/May 1988-February 1990)
Commonwealth's position criminalizing unintentional billing errors is not supported by the Medicaid Fraud statute and is inconsistent with the continued success of the Medicaid program. *Won.*

Purcell v. Bryn Mawr Hospital, et al.*
(Amicus/May 1988-late 1990)
Venue question. *Won.*

Ervin v. Knee* *(Amicus/January 1988-May 1989)*
Does a physician who performs an examination for an insurer owe a duty of care to the patient? *Won.*

Sagala v. Tavares*
(Amicus/November 1987-late 1989)
To prevail in an informed consent case, must plaintiff show causation, i.e., that if he had known of the risks, he would not have consented to procedure? *Lost.*

State Society v. Commonwealth of PA, State Board of Medicine *(Litigation/May 1987-October 1988)*
Constitutionality of regulation promulgated by State Board of Medicine imposing limitations on the use of sympathomimetic amines. *Won.*

Sanderson v. Bryan* *(Amicus/July 1985-March 1988)*
Are confidentiality protections of Pennsylvania Peer Review Protection Act limited solely to information concerning patient who brings the action? *Won.*

Pennsylvania Blue Shield v. Commonwealth of PA Department of Health
(Amicus/May 1984-January 1986)
l) Does the Department of Health have statutory authority to order Pennsylvania Blue Shield to revise its regulations for particular doctors and to compel compliance with approved regulations?
2) Is Department of Health's order that Pennsylvania Blue Shield implement fair and adequate procedures and practices in respect to assignment of accounts, fees and payments, and determination of overpayment disputes a proper exercise of its statutory authority? *Partial win; partial loss.*

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Building Legacies to Medicine

Maria T. Montesano
Assistant Managing Editor

For the past 34 years, LeRoy Erickson has served the State Society in a number of positions, most recently—and most notably—as executive director of The Scientific and Educational Trust. Prior to his retirement at the end of February, LeRoy talked to PENNSYLVANIA MEDICINE about his experiences and accomplishments at the Society, a history of building legacies to medicine.

Just recently, I heard the results of a survey asking people over 95 years old what they would do differently if they had their lives to live over again. Though I admit the answers are hearsay, they seem logical: Some respondents said they would risk more, and others would "take more time to smell the flowers." But overwhelmingly, people just hope to "leave something that's lasting." LeRoy Erickson, retiring executive director of the State Society's Educational and Scientific Trust, just may have done that here in Harrisburg. In his 12 years at the Trust, LeRoy has worked to help more that 1,000 medical students via the Trust's student loan program, several new programs have been added, total assets have more than doubled, and contributions rose to almost a quarter of a million dollars last year alone.

Growing up in Erie

LeRoy fondly reminisces about his childhood in Erie. His father was a glass cutter and businessman, known for his entrepreneurial nature, and his mother worked hard as a housewife and mother of two. LeRoy was active in high school on the stage crew, taking photographs, and as a member of the swim and water polo teams.

LeRoy Erickson

He graduated high school in 1948 and worked six months before heading to Kent State University in Ohio, where he studied business administration. He again was active as a cheerleader and a member of the university's championship gymnastic team.

Following college graduation, LeRoy fulfilled his ROTC duties in the U.S. Army and then returned to Erie, where he got his first job out of school, and was married to Marianne Douds.

The move to Harrisburg

LeRoy came to the Society in 1960 from the Erie County Health and Tuberculosis Association. He had been with the organization for five years, and tells the story of how Carl B. Lechner, MD—an Erie radiologist who, at that time, was a board member of the TB association and medical editor of PENNSYLVANIA MEDICINE, then known as the *Pennsylvania Medical Journal*—first suggested the move.

"Dr. Lechner called me and said, 'Can you come right over to my office?'" LeRoy recounts. "I went over, and there he was, sitting with these red goggles on and his feet propped up on the desk. He said to me, 'I want you to go the Harrisburg. You're the kind of guy we need there. I'll set it up, you get an interview, and that's it.'"

"Harrisburg" meant the State Society, and LeRoy was to call Society staffer John Rineman, then working in public relations. But before LeRoy got the chance to call Rineman, Rineman called him. LeRoy started at the Society on February 1, 1960, as secretary to the Council on Public Service.

At that time, he says, the Society was small but growing. "We would look at membership problems

and the office operation, and we would try to unwind these things and put them back together," he recalls. After a year, he was made Scientific Assembly and Convention manager, and in another year, was promoted to business manager—the Society's first. He stayed in that position for five years, before taking over in 1967 as director of educational affairs.

Among the many national reforms instituted during LeRoy's early years at the Society were Medicare and formal continuing education credits. Though he was unaware of it along the way, his experiences from dealing with the complexity of these and other issues turned out to be stepping stones to his position at the Trust.

The Society's Trust

The Pennsylvania Medical Society's Educational and Scientific Trust was established in 1954 "to serve medicine through charitable, educational, and scientific activities." Its focus back then was public health, and monies were available through a charitable grant (see "History...," below).

But by 1982 things had changed, LeRoy recalls. "The Trust didn't have a lot going on, except for the student loan program. It needed money and didn't have money, and it was thought that something was needed to get the whole program going." That something turned out to be a someone, and that someone was LeRoy.

He had been involved in educational and scientific activities for 14 years, and the leadership at the Society believed LeRoy was their man. John Rineman, who was promoted to executive vice president in 1969, recalls, "LeRoy's personality and characteristics had proved beneficial to the Society, and I believed if anyone could turn the Trust around, it would be LeRoy. It was a new challenge for him."

Abram M. Hostetter, MD, chairman of the Trust, adds, "LeRoy has always been an idea man, reading and connecting what he reads to his other endeavors...One of his greatest strengths has always been that he sees possibilities others don't see."

LeRoy says his own entrepreneurial spirit, which he thinks was inherited from his father, may have helped land him the job, as well. "Under a foundation like this, you have to be entrepreneurial—you have to raise money, get it flowing in. Then you take it and put it back out in some form—loans, grants, programs—as a service to medicine."

In 1982, the Trust was fulfilling its mission solely through its student loan program. By the '90s, however, it was offering much more, including:

- marketing and research projects on health care issues;
- a medical benevolence program, which aids members or immediate families of deceased members who are in financial distress, or provides funds for other charitable uses;
- the Physicians' Health Program (PHP), which promotes the personal and professional well-being of physicians;
- The Institute for Physician Leadership, which seeks to teach physicians leadership and organizational skills to help them adapt to the changing medical environment;
- the Pennsylvania Diabetes Academy, which provides diabetes education to professionals in Pennsylvania; and
- Keystones in Public Health, which addresses public health issues in the commonwealth.

And while the success of the Trust under LeRoy's direction is evident by its program growth, the numbers don't look too bad either: When LeRoy started with the Trust, the annual budget was $80,000, assets totaled $3 million, and there were two employees. Today, the Trust has a budget totaling about $1.5 million, assets of $8.2 million, and 19 employees. Further, in 1993, contributions to the Trust totaled $226,467.

LeRoy credits the success of the organization to the support of the Trust's board and its ability to "gamble a little bit" throughout the years, a staff of "really good people," and the overall nature of the Trust.

Others, however, credit much of the Trust's success to LeRoy—to his intelligence and energy and persistence and ag-

→

THE EDUCATIONAL & SCIENTIFIC TRUST
of the Pennsylvania Medical Society

History of the Trust

The Educational and Scientific Trust was founded by the Board of Trustees of the Pennsylvania Medical Society in 1954 through a grant provided by the A.W. Mellon Educational and Charitable Trust. The Trust was established to serve medicine through charitable, educational, and scientific activities.

While the Trust's initial focus was on public health issues, over the years it has expanded its services to address a broad spectrum of needs in the medical arena. Currently, it offers low-interest loans to medical students, administers the Physicians' Health Programs and The Institute for Physician Leadership, and conducts marketing research on health care issues.

In 1992, the board took action to renew the Trust's commitment to public health by creating "Keystones in Public Health" to promote good health in Pennsylvania through education, networking activities, and coalition building (see article, pages 32-33). The Trust of today remains dedicated to serving the needs of medicine.

gressiveness, his creativity and sensitivity and vision and drive. George Miaoulis, PhD, a long-time consultant to the Trust and long-time friend of LeRoy's, says LeRoy "is a diamond...truly one of the great leaders in the field of medicine, and a role model for all of us."

Being a somewhat modest man, LeRoy offers another possibility for the Trust's success: "I don't know for sure, but maybe someone's been watching over us."

Building legacies

LeRoy's official last day in the office was February 28. He spent his last month at the Society working with new Trust Executive Director Matt Tornambe (see "Moving On," below), and generally just being his usual cheerful self. And why not? He has a lot to be proud of.

When I ask him to talk about his greatest accomplishment, the talk turns to leaving something behind. "Building legacies to medicine—that's the greatest accomplishment." He explains, "The Trust leaves something that is lasting for medical professionals. It carries on a legacy. And I was a part of building that legacy. It doesn't have to have my name on it, but I've got the satisfaction of knowing we've got something in place that is lasting."

In the future, LeRoy is planning to do some consulting, maybe with the Trust; travel; teach; and continue his involvement with safety issues, especially for cyclists—being an avid cyclist himself. He's taken some risks throughout the years and certainly has left something lasting, but LeRoy assures us that in his retirement, he will be stopping along the way to smell the roses.

Moving On

On February 1, 1994, Matthew J. Tornambe joined the Trust, succeeding LeRoy Erickson as executive director. A graduate of Penn State, Matt comes to the Trust from the National Multiple Sclerosis Society in Harrisburg, where he was executive director for 10 years. According to Trust Chairman Abram M. Hostetter, MD, Matt was chosen for the Trust position because he had "ample experience in administration at a nonprofit health organization," and strong references about his work habits and manner.

Matt and LeRoy spent the month of February working together. "It's been great to work right along side of him," Matt says. "Because of what LeRoy has done with the Trust, we can now get back to the original intent of public health issues. I am very excited about that." He adds, "It is unique that a transition like this could go so smoothly. That will certainly benefit the Trust."

Matt says he realizes that he has very big shoes to fill—"because of LeRoy's energy and dedication." But he's encouraged to see parallels between LeRoy and himself. It is those parallels, he says, that give him "a very good chance of picking up where LeRoy left off and moving the Trust positively into the future."

LeRoy sees those parallels as well. "Our backgrounds are similar," he says, "and I see a lot of the same traits in him as I see in myself. It takes a certain spirit or drive to make the Trust work, and I am comfortable that Matt will serve the Trust well."

After two weeks on the job, Matt said, "Things are going great, and I'm learning a lot...The Trust is in a unique position to carry on its medical legacy of philanthropy, [and] because of the strong physician commitment, I am optimistic about my future here."

Ways to Support the Trust

The Trust gives physicians and others interested in medicine the opportunity to contribute to a wide range of worthy projects, including:

- annual giving,
- memorial and honorary contributions,
- planned giving,
- PHP support and contributions, and
- endowment and special funds.

Because the Trust is a nonprofit, 501(c)(3), charitable organization, all gifts are tax-deductible.

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Upgrading Diabetes Therapy

...now that we know it matters

Diabetes Carries High Health Care and Human Costs

Approximately 12 million Americans have diabetes, a chronic disease that can lead to blindness, renal disease, amputation, heart disease, and many other serious disabilities. The economic cost associated with diabetes is over $92 billion per year; and this does not take into account the cost in diminished quality of life of many patients with diabetes.

Diabetes is a complex disease, and ideally, each patient would have a specialized team of health care providers to care for them. But the reality today is that the vast majority of people with diabetes are treated by primary care physicians. It is imperative that physicians have the information and resources they need to formulate an aggressive management plan for their patients with diabetes — particularly in light of convincing new evidence about the efficacy of intense intervention.

Before we discuss the dramatic findings of the Diabetes Control and Complications Trial (DCCT) and what it means for physicians and patients, it will be useful to review the American Diabetes Association's (ADA) standards and the reality of diabetes care in Pennsylvania today. □

1989 ADA Standards Provided Clear Model for Care

In 1989, the American Diabetes Association published its "Standards of Medical Care for Patients with Diabetes Mellitus," which established a model of minimal standards for the care of patients with diabetes.[1]

The ADA standards can be briefly summarized as follows:

Initial Visit—Should include a comprehensive medical history, physical examination to establish or confirm the diabetes diagnosis and review previous treatment. The focus should be on risk factors, symptoms, and treatment of complications of diabetes.

Formulation of Management Plan—Should be designed as a partnership between the patient/family and all members of the health care team and should take into account the patient's condition, lifestyle, age, etc. Education is a key to achieving compliance with the plan, including teaching patients to recognize early signs of acute and chronic conditions requiring attention and self-monitoring of glucose levels.

"... the reality of diabetes care today is that many patients are still not receiving even the basic level of care recommended by the American Diabetes Association."

"Therefore, each physician must keep current the new standards affecting his/her delivery of care."

The management plan should include regular eye examinations and any other needed visits to specialists.

Continuing Care—Stressed as an essential part of the management plan. Patients starting insulin or undertaking treatment changes should be in contact with health care providers as often as necessary (even daily), and other patients should visit their physician quarterly or semi-annually as dictated by their particular circumstances. Such visits should include a glycosylated hemoglobin determination and any other needed lab tests. Each regular visit should include weight and blood pressure measurements, a foot exam, and treatment of symptoms and conditions.

The management plan should also be reviewed for patient compliance and progress toward goals; to identify and follow-up on problems; and to continue patient's self-care education as necessary.

Physician Awareness of Special Considerations—The standards note that illness can aggravate the hyperglycemia of diabetes, requiring changes in treatment. In addition, the standards list several conditions that require special considerations and treatment including diabetic ketoacidosis and hyperosmolar coma; severe or frequent hypoglycemia; childhood and adolescence; pregnancy; retinopathy; and so on. It is stressed that the appropriate medical/diabetes specialists should be consulted in treating patients.

The ADA promulgated these standards to "define basic medical care for people with diabetes," and went on to encourage physicians to provide "more extensive evaluation and management of the patient."

However, the reality of diabetes care today is that many patients are still not receiving even the basic level of care recommended by the ADA. □

In Pennsylvania and Across the Country, Diabetes Care Often Lags Behind the ADA Standards

Across America, most patients with diabetes are treated by primary care physicians, and adherence to the ADA standards is far from universal. One study conducted by the National Institutes of Health in 1992 found that 21% of patients with insulin dependent diabetes mellitus (IDDM) had never tested their blood glucose level and only 40% monitored it at least daily. Forty-seven percent (47%) of patients with non-insulin dependent diabetes mellitus (NIDDM) using insulin never monitored their glucose.[2]

In Pennsylvania, a random telephone survey of primary care physicians in 1988 found relatively low compliance with several important aspects of care for patients with diabetes. Although nearly all physicians said they provided patient education as well as weight and blood pressure measurements, they reported using glycosylated hemoglobin measurements only 1.8 times per year compared to the preferred frequency of four times per year in insulin-treated patients and in non-insulin-treated patients in poor metabolic control.[3]

The diagnosis and treatment of diabetes are problematic from a professional liability standpoint as well. Standards of care such as those promulgated by the ADA carry with them the potential for increased risk with regard to professional liability. In addition to the usual and customary theories of medical negligence, a physician can now be sued for failing to comply with the standards in place. Therefore, each physician must keep current the new standards affecting his/her delivery of care. Concomitantly, it can be argued that these same standards can be protective in that a physician's compliance can be a strong defense should malpractice litigation subsequently be brought against him/her.

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) provides malpractice insurance coverage for approximately 7,000 physician-members of the Pennsylvania Medical Society. The Company's claims experience between 1978 and 1992 includes nearly 200 claims and suits stemming from alleged negligent management of a diabetic patient. With 84% of those cases closed, indemnity payments totaling $12.4 million have been paid on behalf of the named defendants.

PMSLIC's cases demonstrate that the problems of diabetic management are not peculiar to any one or even a few specialties. Rather, defendants represent a wide assortment of medical and surgical specialties, including family and general practitioners, internists, cardiologists, pediatricians, ophthalmologists, orthopedic and plastic surgeons among others. The allegations in these cases go beyond "failure to diagnose" or "negligent treatment" in that many involve treatment of a problem totally unrelated to diabetes but which was complicated specifically because of the patient's disease; for example, the orthopedic management of an ankle fracture in a diabetic patient which ultimately resulted in a below-the-knee amputation, or the prescription of oral contraceptives by an OB/GYN to a young diabetic patient without careful, frequent monitoring of her glucose levels.

On a national level, the Physician Insurers Association of America (PIAA) Data Sharing Project, which includes data from 21 physician-owned and -operated professional liability carriers across the country, shows diabetes to be among the top 20 most frequently occurring and top 40 most expensive conditions contributing to the 102,342 malpractice actions which make up the Project as of June 1993.[4] □

1993 Diabetes Control and Complications Trial Confirms Value of Intensive Therapy

In June 1993, the dramatic results of the Diabetes Control and Complications Trial (DCCT) were made public. The DCCT confirmed that stringent control of blood glucose can prevent or dramatically reduce complications of diabetes, including retinopathy (reduced by 60%); nephropathy (reduced by 56%); and neuropathy (reduced by 60%). The ADA is currently examining its standards to respond to these landmark findings.

The DCCT studied 1,441 volunteers with IDDM over a period of nearly 10 years. The patients, who were between the ages of 13 and 39, were split into two groups to study the effects of conventional diabetes therapy compared to intensive therapy. Conventional therapy consisted of one or two insulin injections each day; daily monitoring of glucose levels; dietary education; and four physician visits a year. Intensive therapy involved three or more insulin injections each day (or use of an insulin pump); four or more glucose tests each day; and intense counseling on diabetes education, diet, exercise, and behavior.

There were risks associated with the intensive therapy. Patients in this group had three times the risk of severe hypoglycemia and were prone to weight gain (already a problem for many patients with diabetes). However, the DCCT Research Group concluded, "We believe that the risk of severe hypoglycemia with intensive therapy is greatly outweighed by the reduction in microvascular and neurologic complications."

Obviously, these findings will cause all physicians and health care professionals who treat patients with diabetes to examine their current practice. The following section provides further details about the parameters of the DCCT study, and sets forth a treatment/management plan for physicians. □

"The dramatic results of the DCCT underscore the importance of good control, periodic assessments of various organ function, and diabetes education. This study will be shared with all of our patients. It is essential that they understand that the extra effort and lifestyle change necessary for following a good diet, frequent monitoring of blood glucose, and additional insulin when necessary, is worth it. However, tight control may not be appropriate for all patients, and the physician must be selective."

—Francine D. Camitta, MD
Endocrinologist
York, PA

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The Pennsylvania Medical Society is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The Pennsylvania Medical Society designates this continuing medical education activity for 2 credit hour(s) in Category 2 of the Physicians Recognition Award of the American Medical Association and the Pennsylvania Medical Society membership requirement.

Reader Survey

Please take a moment to evaluate *"Upgrading Diabetes Therapy...now that we know it matters."* Let us know what you think.

Check each of the following that most adequately describes your opinion:

Was the information in the booklet:	YES	SOMEWHAT	NO
useful?	☐	☐	☐
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easy to apply in your practice?	☐	☐	☐
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THE DEBATE IS OVER

In the spring of 1993, researchers called an early halt to the Diabetes Control and Complications Trial, or DCCT. Launched in the early 1980s, this multicenter study was designed to resolve, once and for all, whether "tight" blood glucose control can help prevent or slow the progression of long-term complications of diabetes, including eye, nerve, and kidney disease. The answer, in short, is **yes.**[1]

THE DCCT DESIGN

In the DCCT, 1,441 volunteers with type I (insulin-dependent) diabetes, ages 13–39, were randomized to one of two diabetes management plans:

- "conventional" therapy, with one or two injections per day, once-daily monitoring of blood or urine glucose, dietary education, and four physician visits a year;
- "intensive" therapy, involving three or more injections per day, or use of an insulin pump, with dosages adjusted on the basis of four or more daily blood glucose tests; intensive diabetes education and dietary, exercise, and psychosocial counseling; and monthly physician visits.

Basic clinical goals

For conventional therapy: "Clinical well-being"—no symptoms of high or low blood sugar; normal growth and development.

For intensive therapy: Blood glucose levels as close to normal as possible.

WHAT THE STUDY SHOWED

Benefits of intensified control

Both groups were monitored for signs of eye, nerve, or kidney disease. Overall, the intensive therapy group experienced a profound reduction in long-term complications.

Intensive therapy reduced

- retinopathy by up to 76%;
- nephropathy by up to 56%;
- neuropathy by up to 60%.

Overall, the intensive therapy group experienced a profound reduction in long-term complications.

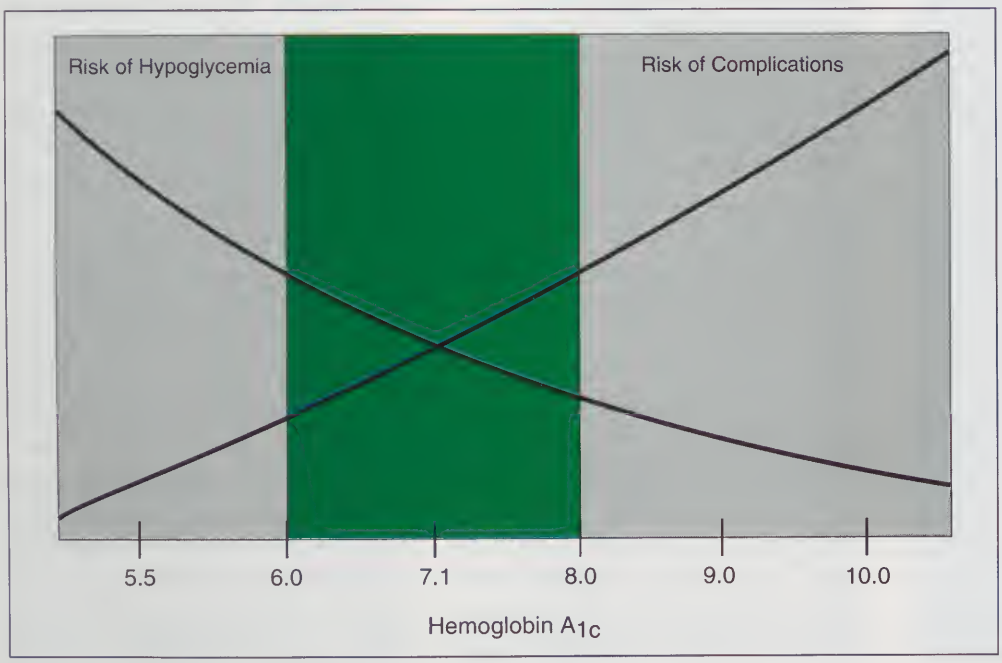


Figure. Artist's conception of principal DCCT findings. Based on results reported in *N Engl J Med* 1993;329:977-986.

The goals you and your patients set *today* for glycemic control can influence your patients' *future* health *substantially*.

The lower the average glycosylated hemoglobin levels (see Figure), the lower the risk for long-term complications.

Risks of intensified control

Despite frequent self-monitoring of blood glucose (SMBG) and close contact with the healthcare team, the intensively treated patients had *three times* as many severe hypoglycemic episodes (those requiring assistance from someone else or emergency room visits) as the conventionally treated patients.

Intensive treatment also promoted weight gain: After five years, intensively treated patients had gained approximately 10 pounds more than conventionally treated patients over the same period.

WHAT THE FINDINGS MEAN TO YOU

The goals you and your patients set *today* for glycemic control can influence your patients' *future* health *substantially*.

DOES THIS APPLY TO ALL PATIENTS?

The DCCT subjects all had insulin-dependent diabetes mellitus (IDDM), also called type I or (formerly) "juvenile-onset" diabetes. This disorder completely destroys a person's insulin-making capacity; insulin therapy is needed for survival. Roughly 300,000 people in the United States have this form of diabetes, which usually develops in youth or early adulthood.

The great majority of people with diabetes have a more common form of the disorder, known as non–insulin-dependent diabetes mellitus (NIDDM), also called type II or (formerly) "maturity-onset" diabetes. This disease usually strikes people who are older than 40 and overweight. Some 6.5 million Americans are known to have NIDDM, and it's estimated that another 6–7 million cases remain undiagnosed.

Although the DCCT findings directly apply only to patients with IDDM, the American Diabetes Association (ADA) has stated that

> **it seems reasonable to recommend tight control in many patients with non–insulin-dependent disease because it is presumed that the mechanisms by which glucose causes complications is the same in both forms of diabetes.[2]**

Although it can persist for years with few or no symptoms, NIDDM is not a "mild" form of diabetes. It also carries a great risk for chronic complications.

WHAT ABOUT OTHER COMPLICATIONS OF DIABETES?

People with diabetes are at increased risk for atherosclerosis—and thus for coronary disease, stroke, and peripheral vascular disease. These complications appear to be less tightly tied to glycemia than eye, nerve, and kidney complications; serum cholesterol and lipids, blood pressure, and smoking history also contribute to macrovascular complications.

Despite the confounding effects introduced by multiple risk factors, the group under intensive diabetes management had fewer coronary and peripheral vascular events than the controls. When all cardiovascular and peripheral vascular events were combined, intensive therapy reduced the risk of macrovascular disease by 41%. When the study ended, this trend was approaching, but had not yet reached, statistical significance. The ADA noted, "[It] is reasonable to suppose

that better [glycemic] control might slow macrovascular in addition to microvascular complications."[2]

HOW INTENSE DOES "INTENSIVE" HAVE TO BE?

What are the magic glucose numbers? Strictly speaking, there are none. The DCCT proved that the risk of long-term complications is lower in people with IDDM who had more ambitious glucose targets than in those with less ambitious targets. The trial wasn't designed to compare risks at specific levels of *actually achieved* control.

That's not to say that the goals weren't specific. The targets of intensive therapy were

- fasting and premeal blood glucose levels 70–120 mg/dL;
- postprandial glucose <180 mg/dL;
- 3:00 a.m. blood glucose (monitored weekly) >65 mg/dL;
- glycosylated hemoglobin (HbA_{1c}) levels as close to normal as possible ("normal" being ≤6.05% in the assay used by the DCCT).

When the DCCT investigators analyzed the findings by plotting average glycosylated hemoglobin levels against the risk of sustained retinopathy progression, the relation proved remarkably straightforward: The lower the mean glycosylated hemoglobin levels, the lower the risk for retinopathy. That result strongly suggests that *any* improvement in blood glucose control is likely to lower the risk of complications to some degree.

MEETING THE STANDARDS OF CARE

The American Diabetes Association has published standards of care for people with diabetes.[3] *If you treat diabetes, you should document your adherence to these standards,* regardless of the specific glycemic targets you and your patients set. A sample checklist of these recommendations appears on page 13.

UPGRADING DIABETES THERAPY

IDDM: BASIC GUIDELINES

The management of diabetes with intensive insulin regimens requires substantial resources and expertise. If your practice is not geared for this kind of treatment approach, it may be preferable to refer IDDM patients to an endocrinologist or diabetes center. At a minimum:

- Every patient with IDDM should take at least two insulin injections a day. If they are taking only two, these should contain a mixture of short- and intermediate-acting insulin. Such a regimen may achieve adequate glycemic control in individuals who eat and exercise on very regular schedules. **However, three or more injections a day or use of an insulin pump should be recommended, unless clearly contraindicated.**
- Every patient with IDDM (or parent of young children with IDDM) should measure blood glucose at least before each injection. They should be taught how to adjust premeal dosages of short-acting insulin on the basis of SMBG results, calorie intake, and physical activity.
- *No patient with IDDM should adjust insulin on the basis of urine glucose tests alone.* Urine tests for ketones, however, should be performed during

TOOLS FOR INTENSIFYING CONTROL

Why has the 50-year debate over blood glucose control and long-term complications been resolved only now? Because the tools for attempting truly tight control have only been in existence since the late 1970s. The key advances, in addition to new drugs and insulin-delivery systems, were two new ways to monitor the effects of diabetes therapy:

- **Self-monitoring of blood glucose (SMBG).** Finger-prick blood glucose tests enable patients to determine their blood glucose level immediately, anywhere. For patients on advanced insulin regimens, SMBG allows precise premeal dosage adjustments. For anyone with diabetes, it can help monitor the effectiveness of treatment and serve as a motivational tool.
- **Glycosylated hemoglobin testing** (also known as glycohemoglobin, glycated hemoglobin, HbA_1, or HbA_{1c} testing). This laboratory test measures the level of glucose-altered (glycosylated) hemoglobin that has accumulated in the blood over the preceding 2–3 months. It's an indispensable gauge of a person's overall level of diabetes control. (**Note:** Different laboratories use slightly different scales for their glycosylated hemoglobin results—blood from a normal volunteer might read 6% at one lab and 7% at another. So know the reference values for the lab you use.)

Patients with IDDM should be taught how to adjust premeal dosages of short-acting insulin on the basis of blood glucose test results, calorie intake, and physical activity.

periods of illness or stress, or whenever blood glucose rises above 240 mg/dL.

- Every patient with IDDM should carry some form of simple carbohydrate (eg, glucose tablets) to counteract hypoglycemia. Family members (and, ideally, co-workers or school personnel) should know how to administer glucagon in the event of severe hypoglycemia.
- Every patient with IDDM should have 24-hour access to a health professional knowledgeable about diabetes.
- Every patient with IDDM should receive education from professionals who can help develop and monitor a diabetes management program; this should include an eating plan, exercise plan, and training on such topics as managing diabetes during sick days and when traveling.

According to the DCCT researchers, IDDM patients for whom intensive diabetes therapy *may not* be appropriate include

- patients who experience frequent severe hypoglycemia or who do not experience the typical early warning signs of hypoglycemia (eg, sweating, trembling);
- patients whose diabetic complications, particularly renal disease, are already far advanced;
- patients with coronary or cerebrovascular disease (whose conditions may be worsened by frequent or severe hypoglycemia);
- children under 13 years. (The DCCT didn't study anyone younger. According to the ADA, tight control is contraindicated in children under 2 years, and should be attempted with extreme caution in those under 7 years.)[2]

NIDDM: A Stepped-Care Approach

The chart running across the centerfold is a simplified guideline for upgrading diabetes therapy in people with NIDDM. It is generalized and does not apply to all patients and situations. The glucose values defining "unacceptable," "better," and "best" are broad estimates, based on typical blood glucose tests. The accompanying glycosylated hemoglobin values are a somewhat more reliable guide.

Key points

- *Resource inventory.* Before intensifying a patient's therapy—indeed, before treating diabetes at all—you should take stock of the resources and knowledge needed to apply the regimen successfully. If they are not available, it may be preferable to refer the patient to a specialist or diabetes treatment program. Resource needs grow cumulatively with more advanced diabetes treatment regimens.
- *Go for the green.* The object is to improve blood glucose control from the red "unacceptable" zone (BG >200 mg/dL; HbA_{1c} >10%) to the green "best" zone (BG <140 mg/dL; HbA_{1c} 6–8%), where the best chances of preventing complications reside.
- *The middle ground.* The yellow ("better") zone corresponds roughly to conventional control in the DCCT. At this level of control, a patient will likely feel well most of the time. But the risk of complications is significantly higher than that for patients in the "best" zone.
- *Document discussions.* There may be sound reasons why you

and your patient decide that "better" is good enough. But in light of the DCCT, make sure your patient understands that lower blood glucose levels will likely decrease the risk of complications, and document that discussion. Patients who develop complications in the future will have reason to ask whether their doctors took aggressive enough steps to move them from "better" to "best." You should also advise the patient of the increased risk of hypoglycemia if a decision is made to intensify therapy.

STEP 1: DIET AND EXERCISE

Resource inventory

- Education capability for meal planning, exercise counseling, and (if required) weight loss
- Diabetes education capability (nurse/educator if possible)
- Minimum testing:
  —Glycosylated hemoglobin
  —Lipid profile
  —Microalbuminuria, serum creatinine
  —ECG, BP

For an individual newly diagnosed with NIDDM and without acute symptoms of diabetes, the first-line therapy is a diet and (if not medically contraindicated) exercise plan. In some patients, these measures may be all that's needed to control diabetes adequately, although about 85% of NIDDM patients do eventually require medication. Even then, diet remains essential. In fact, dietary backsliding is at the root of many medication "failures."

Dietary goals. For obese NIDDM patients—the majority—the primary dietary goal is weight loss. When patients lose weight, their tissues become more sensitive to insulin and thus remove more glucose from the blood; weight loss also reduces glucose production in the liver.

In addition to calorie restriction, dietary goals include

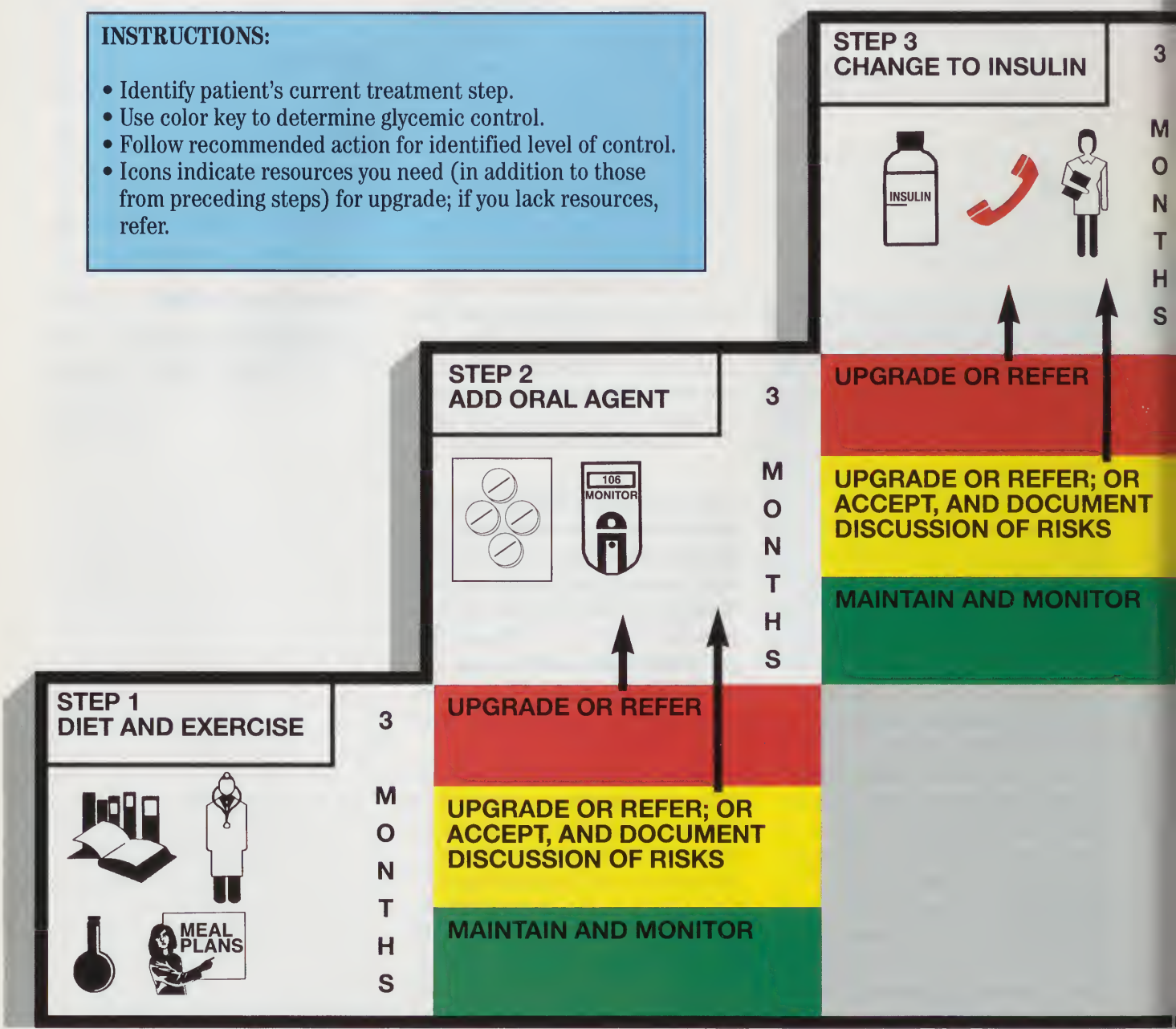
- distributing calories as evenly as possible throughout the day, to avoid large after-meal glucose "excursions";
- maintaining a balanced diet, with about 50–60% of calories from carbohydrates (especially high-fiber foods), no more than 30% of calories from fat, and the balance from protein. In other words, a basic "heart healthy" diet;
- moderation in sugar and alcohol consumption. For most patients, strict prohibition of either is no longer considered necessary. Sugar taken as part of a balanced meal should not raise blood glucose dramatically.

If you have the expertise and the time, you can sit down with the patient, explain how food affects diabetes control, and help him or her develop a sensible and palatable meal plan. But weight loss is difficult, and you will probably need to enlist the aid of a registered dietitian or refer your patient to a local, reputable weight-loss program.

Exercise. Physical activity (specifically, aerobic exercise, as opposed to resistance training) lowers blood sugar acutely. Aerobic conditioning also increases the body's overall sensitivity to its own insulin, aids weight loss, and has a favorable impact on serum lipids. If a patient is new to exercise and over age 35, an exercise tolerance test is recommended to make sure

About 85% of NIDDM patients eventually require medication. Even then, diet remains essential.

UPGRADING GLYCEMIC CONTROL IN NIDDM: A STEPPED–CARE APPROACH



STEP 4
INTENSIVE INSULIN THERAPY

24 hours

3 MONTHS

REFER!

REFER; OR ACCEPT, AND DOCUMENT DISCUSSION OF RISKS

MAINTAIN AND MONITOR

UPGRADE OR REFER

UPGRADE OR REFER; OR ACCEPT, AND DOCUMENT DISCUSSION OF RISKS

MAINTAIN AND MONITOR

COLOR KEY

UNACCEPTABLE

BG >200 mg/dL; HbA_{1c} >10%

BETTER

BG 140–200 mg/dL; HbA_{1c} 8–10%

BEST

BG <140 mg/dL; HbA_{1c} 6–8%

RESOURCE KEY

Physician

Nurse/educator

Diabetes education

Lab tests

Dietitian

Blood–glucose monitoring

Oral hypoglycemic agents

Insulin

Hotline access

Psychological counseling

Glycosylated hemoglobin testing should be performed at least twice a year in all people with diabetes.

there is no underlying vascular disease. If an examination yields no reason to avoid exercise, recommend it. If the patient has no idea how to begin, you can have phone numbers of local exercise programs ready or suggest a trip to an exercise physiologist for help in developing a personalized program. If the patient has significant vascular disease, an exercise program should not be recommended until an appropriate medical evaluation has been completed.

Monitoring. If you treat diabetes, you must become familiar with glycosylated hemoglobin testing. When you are instituting or changing therapy, a baseline glycosylated hemoglobin test, followed by another in a few months, is an excellent way to see whether the patient's glycemic control has actually improved. This laboratory test should be performed *at least twice a year in all people with diabetes,* according to standards of diabetes care developed by the American Diabetes Association.[3]

If diet and exercise alone achieve acceptable control, glycosylated hemoglobin testing during periodic checkups may be all the glucose monitoring needed. However, all patients should be encouraged to learn SMBG and use it regularly to determine how their treatment plan is working.

Monitoring for complications. Monitoring your patient for signs of long-term complications is also essential from the very start. Because NIDDM often goes undiagnosed for years, it's not unusual to discover signs of complications at the time diabetes is diagnosed. One fairly new resource in this regard is microalbuminuria testing—a way of detecting minute quantities of urinary protein. Even if a standard urine dipstick test turns up negative for protein, microalbuminuria could indicate early signs of diabetic kidney disease, a strong argument for intensive glucose control. Vigorous control of hypertension, if present, has also been shown to help slow the progression of nephropathy. Also, all people with diabetes who are older than 30 years or have had diabetes for at least 5 years should have yearly ophthalmic exams.

STEP 2: ADD ORAL HYPOGLYCEMIC AGENT

Resource inventory

- Resources as for Step 1
- Oral agent selection rationales
- Education on dosage, timing, adverse drug interactions, and hypoglycemia
- SMBG training

If, after a 3–month trial of diet and exercise, the regimen does not bring blood glucose concentrations into an acceptable range, or if it achieves "better" control when "best" is the agreed-upon goal, adding an oral hypoglycemic agent (OHA) is usually the next step. Like all clinical judgments, this is not an ironclad rule. Many physicians would consider insulin the first-line drug in some patients, eg, young, lean individuals with NIDDM.

A common side effect of sulfonylureas is hypoglycemia. Because research and clinical experience show that many patients cannot sense hypoglycemia correctly—and may treat for it when their blood glucose levels are in a normal range—those on OHAs also need to be trained in SMBG. SMBG can help document the effectiveness of treatment, confirm hypoglycemic episodes, and aid in recognition of high blood glucose levels caused by mistaken or excessive treatment for hypoglycemia.

Neither doctor nor patient should be lulled into thinking that an OHA, or insulin for that matter, is a license to abandon diet and exercise.

STEP 3: CHANGE TO INSULIN

Resource inventory

- Resources as for Steps 1 and 2
- Nurse/educator availability for education on insulin dosage, timing, injection techniques, hyper-, and hypoglycemia
- Dietitian availability for coordinating meal plan with insulin injections.
- HbA_{1c} testing 2–4 times a year
- Physician accessibility during dosage adjustment periods

If OHAs at the maximum recommended dosage do not bring blood glucose concentrations out of the unacceptable range within 3 months, if they achieve "better" control when you and your patient have agreed your goal is "best," or if they work for a time and then lose their effectiveness, the next step is insulin. Within the first year of use, OHAs prove insufficient in about 30% of patients; they lose effectiveness in 5 to 10% of users each year after that.

The framework of these simplified guidelines incorporates four sequential steps: 1) diet and exercise, 2) addition of OHAs, 3) change to insulin, and 4) intensive insulin therapy. In some cases, physicians have found that they could achieve more normal blood glucose concentrations and extend the period of OHA use by adding an injection of intermediate-acting insulin at bedtime.

Note that NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes an insulin-requiring person with non–insulin-dependent diabetes.

In NIDDM, unlike IDDM, a regimen of two daily insulin injections stands a reasonable chance of achieving adequate—in some patients even excellent—glycemic control. Such success is most likely when NIDDM is of recent onset with relatively mild hyperglycemia.

A reasonable initial dose of insulin is 0.25 units per pound of body weight per day. Common two-injection insulin regimens, in order of increasing complexity, include

- Two injections of intermediate-acting insulin, two-thirds before breakfast and one-third before supper;
- Two injections of premixed insulin (eg, 70% NPH, 30% regular), two-thirds before breakfast and one-third before supper;
- Two injections of mixed short- and intermediate-acting insulin, where the dosage of the short-acting insulin is adjusted according to premeal SMBG test results and the anticipated size of the meal.

STEP 4: INTENSIVE INSULIN THERAPY

Resource inventory

- Resources as for Steps 1–3
- 24-hr hotline
- SMBG ≥4 times daily
- Nurse/educator availability for intensive training on hypoglycemia (awareness, prevention, treatment) and for advanced insulin dosage adjustment training
- Availability of professional help for emotional and motivational counseling

NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes an insulin-requiring person with non–insulin-dependent diabetes.

Intensive insulin regimens are not common therapy for NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance.

If two injections per day, even in a split/mixed regimen, do not bring blood glucose concentrations into an acceptable range, or if they achieve "better" when you want "best," the last option is multiple-injection or insulin pump therapy: the "intensive" regimens used in the DCCT. These are not common regimens for treating NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance. They require experienced and available health professionals, and a dedicated, motivated patient.

Typical multiple-injection regimens include

- Three SMBG-adjusted premeal injections of regular insulin, with intermediate-acting insulin mixed in at supper, to cover glycemia overnight;
- Three-injection regimen consisting of 1) a prebreakfast injection of intermediate- and short-acting insulin, 2) a presupper injection of short-acting insulin, and 3) a bedtime injection of intermediate-acting insulin to last all night;
- Three SMBG-adjusted premeal injections of regular insulin plus an injection of long- or intermediate-acting insulin at bedtime.

Insulin pumps, preferred by some patients, are computerized, motor-driven syringes that deliver insulin to a subcutaneous catheter. The pump, which contains short-acting insulin only, delivers a small amount constantly (the basal delivery) and allows the patient to adjust premeal doses (boluses) on the basis of SMBG results.

Unless you are already part of a team that includes, at a minimum, a diabetes nurse/educator, dietitian, and mental health professional, and unless a knowledgeable team member is available to answer questions 24 hours a day, it's best to leave these intensive regimens to diabetes specialists.

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2. American Diabetes Association. Position statement: implications of the Diabetes Control and Complications Trial. *Diabetes Spectrum* 1993;6:225-227.
3. American Diabetes Association. Clinical practice recommendations. Standards of medical care for patients with diabetes mellitus. *Diabetes Care* 1993;16(Supp 2):10.

Patient's name _____

Clinical Practice Recommendations for Diabetes Mellitus

This guideline indicates minimum standards of continuing care for stabilized patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care.

Indicate task was performed by initialing box. Shaded boxes are optional tasks.

VISIT	Initial	3 mo.	6 mo.	9 mo.	Annual	3 mo.	6 mo.	9 mo.	Annual
DATE									
PHYSICAL									
Complete history and physical									
Height and weight									
Blood pressure									
Ophthalmoscopic exam									
Foot exam									
Interim physical and history									
LABORATORY									
HbA_{1c}									
Random plasma glucose									
Lipid profile									
Urinalysis									
Microalbuminuria									
Serum creatinine									
ECG									
DOCUMENT GOALS AND MANAGEMENT PLAN									
REFERRAL TO OPHTHALMOLOGIST									

Adapted from *Diabetes Care* 1993;16(Suppl 2):10.

ICD-CODES:
250.00 NIDDM
250.01 IDDM
250___ OTHER COMPLICATIONS

Good News About Your Diabetes

Scientists have just proved that controlling blood sugar *carefully* can help prevent the long-term complications of diabetes.

A study called the Diabetes Control and Complications Trial (DCCT) compared two groups of people with diabetes:

- Those who controlled their blood sugar well enough to avoid extremes of high and low blood sugar and to feel well most of the time.
- Those who worked closely with doctors, nurses, and others to keep their blood sugar as near to normal as possible.

IT REALLY WORKED!

The extra effort paid off! People who worked harder to keep the amount of sugar in their blood near normal had fewer signs of diabetic eye, kidney, and nerve disease at the end of the 6 1/2-year study. These long-term problems were reduced by more than half. Keeping blood sugar as close to normal as possible also tended to lower the risk of heart disease and poor leg circulation.

WHO CAN BE HELPED?

The study was done only in people taking insulin, but experts agree that all people with diabetes—whether they're treated with diet or pills or insulin—can lower their risk of complications by improving their blood sugar control.

THE TRADE-OFF

But when you aim for normal blood sugar levels, you increase the chances of overshooting the target and lowering sugar levels too far. This is true mainly if you take insulin, but it can also occur if you take diabetes pills. In the DCCT, the group working toward normal blood sugar had three times more low blood sugar reactions than the other group. You can learn to watch out for these reactions and prevent or correct them, but they can be dangerous if not treated quickly and properly.

One other downside: if you take insulin several times a day, controlling blood sugar more tightly can cause some weight gain because insulin helps your body store calories better.

WHAT TO DO?

Ask your doctor about the DCCT and whether a change in treatment makes sense for you. Changing your treatment plan today could make a big difference to your health in the future.

WHAT ELSE IS NEW?

Diabetes experts recently spelled out the basic steps that all health professionals should follow for people with diabetes.

Whenever you visit your doctor or clinic, expect to discuss:

- how well your treatment plan is working
- the target glucose levels you're aiming for
- your blood glucose self-monitoring results
- any high or low blood glucose results
- your medications
- any changes in your routine

And you should have these checked:

- your weight
- your blood pressure
- your blood glucose
- your feet and eyes

You should also have a *glycosylated hemoglobin* test: it provides a snapshot of how well your blood glucose was controlled over the last 2–3 months.

BETWEEN VISITS

Write down your test results and make notes about things you want to talk about.

EVERY YEAR

You should have these tests:

- cholesterol
- triglycerides
- an electrocardiogram (heart test)
- kidney function
  —creatinine in blood
  —protein in urine
- a complete eye exam by an eye doctor

ASK QUESTIONS

And remember: the most important person on your healthcare team is **you**!!

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Managing Cancer's Pain

Maureen Hoepfer

Dr. Simmonds

Mary Simmonds, MD, is a clinical assistant professor of medicine at Penn State's College of Medicine and is also in private oncology practice in Cumberland County. She is one of the founders and now serves as co-director of the Pennsylvania Cancer Pain Initiative, a voluntary statewide organization of individuals concerned with cancer pain issues.

This year nearly six million people will be diagnosed with cancer. Of these, more than two-thirds will experience pain at some time during their illness. Between 50 and 80 percent of these patients will receive inadequate pain relief—not because their pain is not receptive to therapy, but because they are undertreated.

Despite major advances in the detection and treatment of cancer, Mary Simmonds, MD, says many cancer patients suffer in silence because physicians fail to adequately manage their pain. Misconceptions, cultural biases, and a lack of education on the subject contribute to this situation.

"It's ironic. I read a survey one time that revealed that the number one reason people go to doctors is because they have some sort of pain," Dr. Simmonds says. "Yet, medical education is geared toward teaching the diagnosis and treatment of a disease so the symptoms go away. It is not geared as much towards treating specific symptoms, such as pain. We do a poor job of teaching medical students how to deal with pain."

The tragedy of cancer pain is that almost all of this pain can be relieved by common modalities. Because medical education emphasizes the treatment of cancer, the relief of associated pain is often a secondary goal, she adds.

Misconceptions about pain

Treating cancer pain is also affected by various attitudes and misconceptions that are common in this country, Dr. Simmonds contends. For example, systemic analgesics, including opiates, are the mainstays of cancer pain treatment. Unfortunately, one of the chief barriers to adequate cancer pain treatment is fear of narcotic addiction. Significant confusion exists among patients and physicians about tolerance to such drugs, physical dependence on them, and psychological dependence or addiction.

Dr. Simmonds says tolerance develops in many patients who take opiates over a long time. Since developing tolerance can cause concern among patients, it's important to make patients understand that tolerance is not addiction, that higher doses may become necessary with time, and that this does not in itself signal disease progression or addiction, she explains.

Physical dependence is distinct from true addiction. Dr. Simmonds says 99 out of 100 cancer patients never become physically dependent on an opiate. These patients often refrain from taking their drugs on a regular schedule. It is rare that cancer patients suffer withdrawal symptoms from taking opiates, she explains. This would occur only if physical dependence had developed.

True addiction involves psychological dependence and is also very rare among cancer patients, according to Dr. Simmonds. Addicted individuals develop a craving for the narcotic and arrange their lives to obtain the drug and induce euphoria.

In contrast, cancer patients use narcotics simply to achieve some measure of comfort. She adds that experts estimate fewer than one in every 100 narcotic addicts were introduced to the drug in a medical setting.

Some practitioners also fail to adequately manage a patient's cancer pain because they fear they could be indicted for misprescribing if their patients require high opioid doses. "There are many doctors who think they will be turned into the authorities for prescribing opiates," Dr. Simmonds explains. "They fear their ID number will be fed into the computer, and they're going to be raided. Although the

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

Drug Enforcement Agency does check, as long as you're licensed to prescribe opiates, you have the authority under Pennsylvania law to use these drugs to help relieve your patient's pain."

Cultural biases

The cultural interpretation of pain is another barrier to adequate treatment, Dr. Simmonds says. The attitude that suffering must accompany illness is strongly ingrained. Many patients are reluctant to report pain to their physicians, fearing they will be seen as complainers. Since consultation time is brief, some patients are afraid they will distract the physician from treating the disease if they complain of pain. Also, many patients think complaining about pain will alarm family members by suggesting the cancer has advanced.

"Physicians themselves are affected by their own cultural biases," she says. "A physician who comes from a stoic background and one whose background is more effusive will have different ideas about their own patient's pain." Education of both the health professional and the public is the key to better management of cancer pain, she says.

Pennsylvania Cancer Pain Initiative

The Pennsylvania Cancer Pain Initiative (PCPI) proposes to use education as the primary vehicle to achieve its goal: To reduce suffering from cancer pain.

The voluntary effort began in the fall of 1988 after Dr. Simmonds and Peter Houts, PhD, of the Department of Behavioral Medicine at Penn State's Milton S. Hershey Medical Center and PCPI's other co-director, attended an international conference on cancer pain in New York. At the conference, they heard a presentation about an innovative program that began in Wisconsin in 1984, the Wisconsin Cancer Pain Initiative. That organization's efforts defined the scope of the problem in the state, started educational programs for both cancer patients and health professionals, and initiated lobbying campaigns for needed legislative and regulatory reforms.

Drs. Simmonds and Houts took the idea of instituting a Pennsylvania Cancer Pain Initiative to the Pennsylvania Department of Health's Division of Health Cancer Control. The idea fit with the goals of the Pennsylvania Cancer Control Plan, and PCPI received a funding grant which began in September 1989.

Since then, PCPI has grown to include 700-plus supporters representing 53 counties, and more than 100 hospitals and health care facilities throughout Pennsylvania. Those involved include physicians, nurses, pharmacists, social service personnel, public officials, community leaders, and persons diagnosed with cancer and their families.

The organization is headed by a 13-member steering committee and employs a part-time nurse administrator. Dr. Simmonds says much of the organization's work is accomplished through its committees: Medical Practice, Nursing, Pharmacy, Media, Regulatory, and Public Education.

Since PCPI began, the group has focused primarily on educational activities (see upcoming events, at right), but also publishes a quarterly newsletter and has a speakers bureau available to hospitals, medical organizations, and community groups.

"We also act as a clearinghouse for both patient and professional information about cancer pain management, " Dr. Simmonds says. "Through our Nursing Committee, we have developed a patient education brochure on this issue, and we have been collecting information about other published materials, videotapes, and audiotapes currently available for both oncology professionals and patients regarding cancer pain."

In October, PCPI will sponsor its first Cancer Pain Role Model Program in Hershey. Dr. Simmonds explains this program trains physicians and nurse educators in pain assessment and treatment so they can return to their institutions and teach their colleagues analgesic principles.

In addition, on March 2, the Agency for Health Care Policy and Research (AHCPR) released guidelines on cancer pain management. PCPI will play a major role in disseminating these guidelines to health care professionals and promoting their use.

"Pennsylvania was one of the first states after Wisconsin to establish a Cancer Pain Initiative. But more and more states are now becoming aware of the importance of cancer pain management and beginning their own initiatives. In fact, the American Cancer Society recently decided to address this issue on a national level," Dr. Simmonds says. "PCPI is an all-volunteer effort. Sometimes I ask myself, 'Are we doing enough?' We have a difficult goal, but hopefully our collective efforts will make a difference in reducing the suffering related to cancer." ⬡

PCPI Upcoming Events

April 15, 1994

Cancer Pain Management: Philosophy, Policy, and Practice

PCPI's annual educational conference will be held at the Harrisburg Holiday Inn East. Topics will include: integration of cancer pain management into health care policy, pediatric cancer pain, special needs of the elderly, and ethical decision making.

October 1, 1994

The Cancer Pain Role Model Program

Physicians and nurse educators who attend this one-day, "train-the-trainer" program, to be held at the Hershey Lodge and Convention Center, will learn about the assessment and treatment of cancer pain, patient and family education techniques, and methods of effective consultation and professional education. After training, participants will be better able to train their colleagues about methods to manage cancer pain.

For more information on these offerings or how to become more involved in the initiative, call PCPI Executive Director Georgia Trostle, RN, at (717) 531-6849.

MENINGOCOCCAL DISEASE: A CALL FOR VIGILANCE

The newspaper headline screams up at you, "Student Stricken with Meningitis!" You remember how your patient presented: Her symptoms of cough, headache, and sore throat were typical of the many other cases of upper respiratory tract infection you had been seeing in your practice. However, she seemed more ill than usual, and you had insisted that she return to see you if she felt worse, or the following day if there was no improvement.

By her return the next day, she had developed fever, nausea, and headache, and on reaching the hospital for admission, she had become lethargic. Her white count was elevated with increased polymorphonuclear leukocytes. Her cerebrospinal fluid pressure and protein were increased, the CSF PMN count was 20,000 per microliter, and the glucose was low. The Gram stain was non-diagnostic, but the CSF latex agglutination indicated the presence of *Neisseria meningitidis.* These results were confirmed when both blood and CSF cultures yielded the organism. Serogrouping, essential for appropriate public health measures, was in progress at the Pennsylvania Department of Health Bureau of Laboratories in Lionville.

After diagnostic tests were completed on admission, antibiotic therapy had been instituted immediately with Penicillin G—20 million units per day—and she had responded well. Your prompt report to the health department and your student's university had initiated the search for contacts in need of prophylaxis, and the distribution of information to relieve the fear and anxiety of those in contact with your patient.

N. meningitidis is a natural inhabitant of the human oropharynx. Transmission is from person to person through the inhalation of aerosolized nasopharyngeal secretions. Colonization with the closely related *N. lactamica* (which does not cause disseminated disease) during the first few years of life, followed by colonization with *N. meningitidis* through the teenage years, includes development of group-specific antibodies. Two to 30 percent of individuals may carry the organism in their nasopharynx, while carriage rates in teens are typically 15-25 percent. Carriage rates in close contacts of a patient with invasive disease may be as high as 40 percent.

It is generally thought that carriers, and not patients, are how this disease is spread, and that case-to-case transmission is rare. Thus, identification of carriers by throat culture does not determine those in need of prophylaxis. The incidence of invasive meningococcal disease is relatively rare, as discussed below. However, the attack rate in household contacts of a case is up to 1,000 times the overall rate, and during epidemic periods, may be 15,000 times the overall rate. It is on that basis that antibiotic prophylaxis of intimate contacts of individual cases is recommended (see box below).

Epidemiology and public health considerations

In Pennsylvania, cases of meningococcal disease are sporadic. In 1992, 96 patients were diagnosed with invasive meningitidis caused by *N. meningitidis.* Seven (7 percent) of these individuals died. In 1993 there were 94 reported patients with 13 deaths (14 percent). Overall incidence of meningococcal disease was 0.8 cases per 100,000 Pennsylvania residents for both 1992 and 1993 (based on 1990 census figures), although rates from Philadelphia and several counties statewide were two to four times higher than this baseline figure during the two-year period.

In a suspected meningococcal outbreak or cluster, "first line" medical evaluation is crucial for successful public health assessment and effective intervention. The first priority after treating and stabilizing the patient is to identify, contact, and prophylax *direct, close contacts* (see box below).

Neisseria meningitidis is contained in large droplets that result when a person sneezes or coughs. Bacteria contained in these droplets usually fall quickly to the floor and, when dry, become non-infectious. Most transmission of the bacteria from one person to another results from prolonged close contact, or by direct contact with nasopharyngeal secretions. Close or prolonged contact is defined as having intimate contact, living in the same house/dorm room, or, if less that five years of age, attending the same day care facility as the index patient.

It must be stressed that casual contact (such as shaking hands, riding in the same bus, or attending the same lecture) and formite contact (such as contact with utensils or inanimate objects) does *not* represent a significant source of exposure to meningococcal disease in adults. A child, especially one with respiratory symptomatology in a day care center, makes a more effective transmission source of the etiologic organism that an adolescent or adult. Health care workers who follow routine universal precautions during patient contact—even those who care for patients diagnosed with meningitis—are at low risk of meningococcal infection unless they have had mouth-to-mouth contact with the patient.

Several recent outbreaks of meningococcal disease have led to targeted mass vaccination campaigns. The decision to immunize a patient or a community must be carefully made using some specific guidelines.

Chemoprophylaxis for Close Contacts of Meningococcal Cases

Rifampin: 600 mg every 12 hours for two days for adults (4 doses); use 10 mg/kg for children older than one month; use 5 mg/kg for children less than one month

Ceftriaxone: Only shown effective against Group A; single I.M. dose of 250 mg for adults; use 125 mg for children under 15 years

Ciprofloxacin: For adults only; 500 mg single oral dose

Sulfadiazine (if sensitive): Not effective for many strains resistant to sulfa; 1 g every 12 hours for two days for adults and older children (4 doses); use 125-150 mg/kg/d divided into four equal doses for each of two days; for infants and children (8 doses)

Reference: *Benenson, AS. Control of Communicable Diseases in Man, 1990.*

Bacterial isolation and rapid serogroup identification is an essential step. An increase of confirmed disease occurrence above baseline incidence, as well as the identification of a specific population at increased risk for infection, are two additional parameters which must be established.

A safe meningococcal polysaccharide vaccine, a quadrivalent A, C, Y, and W-135 vaccine given as a single dose, is available for use in the U.S., but routine use is not recommended for several reasons:

1) The vaccine is *not* effective against serogroup B meningococcus which accounts for the majority of isolates from sporadic cases.

2) The vaccine does not always provide adequate immunity when administered to children under the age of 2 years—the main age group acquiring the disease.

3) Vaccination is the incorrect alternative to prompt contact identification and chemoprophylaxis.

4) Serogroup specific immune response produced by the vaccine is of unknown duration so that booster doses would frequently be necessary if population-wide immunity was a desired outcome.

About two percent of vaccinees may develop soreness, localized erythema, and/or low-grade fever lasting one to two days. The risk of severe or life-threatening allergic reactions is probably less than one in 100,000 vaccinations.

Meningitis, as well as all types of meningococcal disease, are *mandatorily* reportable conditions within the commonwealth. Physicians who are not sure of their local health jurisdiction should contact the Pennsylvania Department of Health Division of Communicable Disease Epidemiology at (717) 787-3350 (7:30 a.m.-4:30 p.m., Monday through Friday) or (717) 737-5349 (evenings, weekends, and holidays).

Laboratory isolates should be forwarded immediately to the Pennsylvania State Public Health Laboratory in Lionville for Serogroup identification. To arrange shipment samples, call (610) 363-8500.

Controlling Meningococcal Disease

Sporadic Cases

1. Report to health department
2. Antibiotic prophylaxis to close contacts
3. Surveillance for symptoms and new cases
4. Information distribution

Clusters or Outbreaks

In addition to the above, vaccination of a specific population only if:

a. Ongoing transmission
b. Vaccine preventable serogroup (A, C, Y, W-135)
c. Defined population
d. Increased rate

Contributed by Maria Moll, MD, and Hugh Mainzer, DVM, MS. Dr. Moll is an epidemiologist, Division of Communicable Disease Epidemiology, Pennsylvania Department of Health. Dr. Mainzer is an Epidemic Intelligence Service officer, U.S. Centers for Disease Control and Prevention, assigned to the Pennsylvania Department of Health.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Recognizing the Chemically Dependent Physician

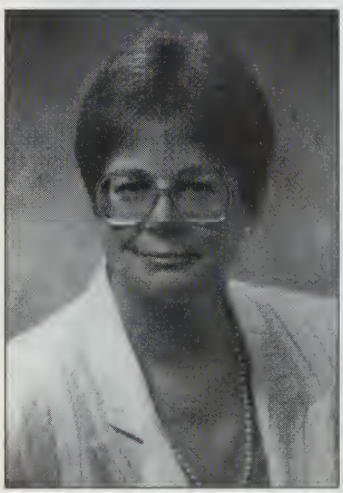
Penelope P. Ziegler, MD

When drug and/or alcohol abuse is suspected in a physician, action must be taken as soon as possible to provide intervention and treatment. This article overviews the signs and symptoms of impairment, explains the barriers to identifying the problem and getting help for the physician, and offers resources for impaired physicians and their colleagues, family, and friends.

Physicians have become increasingly knowledgeable about alcoholism, drug addiction, and related disorders in recent years. As the body of scientific research and the public's awareness of these problems increase, more and more patients are identified and referred for treatment by their primary care physicians. In addition, medical practitioners are alert to the addictive potential of certain classes of drugs and are careful to observe their patients' use of these medications, detecting signs of abuse, and/or dependence at an early stage.

Yet, despite the improving climate for recognizing addictive disorders, physicians who themselves are experiencing problems related to the use of alcohol and other drugs often are not identified and referred for treatment until late in the course of their illnesses. Delayed recognition of substance use disorders in physicians raises concern on a number of levels:

- The prognosis for successful treatment and reentry into practice is improved by early prevention, prior to the development of major medical complications and/or irreversible organ damage.
- The chemically dependent physician's recovery process is smoother and less stressful if treatment begins before serious legal, interpersonal, and professional complications take place.
- Early intervention can be effective in preventing injury to patients, liability to the hospital, and damage to the physician's reputation.



Dr. Ziegler is medical director of the Physicians' Health Programs of the State Society's Educational and Scientific Trust.

With these clear benefits resulting from early detection of problems, why are so many physicians referred only in the advanced stages of addictive disease?

Denial: a case in point

Many different barriers operate within the medical profession to prevent or delay the identification of impairment in practicing physicians. The first and most important of these is *denial.*

Denial is a term used to refer to a collection of psychological mechanisms by which persons with chemical dependency, as well as those close to them, fail to see the reality of what is happening, i.e., the addicted individuals' progressive loss of control and inability to stop drinking or drugging. It can be blatant or subtle, taking the form of rationalization, blaming of other persons or circumstances, etc.

An example of denial in the medical profession involves a 40-year-old married male internist whose drinking has become increasingly out of control over the past few years. For the past six months, in addition to alcohol, he has been using self-prescribed oral opiates (Percocet, Vicodin, etc.) for headaches and back pain, as well as benzodiazepines (Xanax, Halcion) to control insomnia and anxiety. He blames the drinking and pill use on the stress of practice and on his growing marital problems.

At the office, his secretary struggles to reschedule missed appointments and to calm the waiting room full of patients as the physician falls further behind and cannot seem to get to work on time. She also worries about the deterioration in his appearance—he is losing weight, neglecting his grooming, and badly needs a haircut—but she is afraid to say anything. What if he gets angry and fires her? Besides, he is obviously under a lot of stress, and she doesn't want to make things worse.

The two medical assistants are also concerned but are keeping a low profile. They have noticed how he pockets sample drugs, but do not know if they should say anything, even to each other.

The physician's colleagues at the hospital have noticed similar changes but aren't certain what to make of them. They wonder if his haggard appearance and weight loss are related to the marital problems they have heard rumors about. He seems stressed out, always in a rush, never having time to discuss a case or a new procedure. He has become too busy for social activities such as golf or a dinner party. His sense of humor has all but disappeared, and he is frequently irritable and hypercritical.

The nurses are surprised and distressed by the radical change in his personality. As a resident, he had been a favorite of the nursing staff because of his warm, emphatic style of relating and his gentleness with patients. Now he has become distant, abrupt, and impatient, rarely smiling and never laughing. Several times the emergency room nurses have caught a hint of alcohol on his breath at night when he came in to see a patient. They were concerned but weren't willing to fill out a report which might add to his troubles, whatever they were.

One of the pharmacists in town has noticed that, on three occasions, the physician has written prescriptions for controlled drugs for members of his family and has picked up the pills himself. The pharmacist has been taught that this behavior is a "red flag," an indicator of possible drug abuse. However, he has known the physician for years and cannot believe that he, of all people, would abuse drugs. There must be another explanation. Perhaps the doctor's family members do need the medication for pain, anxiety, or insomnia.

At home, the physician's wife is aware that he is drinking too much. She has tried to talk with him about her concerns, but this only results in arguments or his increased withdrawal from her and the rest of the family. She wonders if his need to escape into the bottle is her fault. Perhaps if she were doing a better job of insulating him from the stresses of his professional and family life, he wouldn't need to drink so much. She makes excuses for him in social settings, and takes over more and more of the things he used to do around the house and in the community. She tells no one about her concerns—she is too ashamed and afraid of what could happen to his practice and to the family.

The couple's 12-year-old son, who is a talented tennis player taught and encouraged by his father, has dropped off the tennis team of his junior high school. He has started bringing home Cs and Ds instead of his usual As, and is increasingly hostile and argumentative with his mother. Their 10-year-old daughter's teacher has expressed concern over the child's daydreaming and inattention in class, and has asked if something is wrong at home. At times the children tell their mother that they are afraid of Dad's temper when he has been drinking. They no longer bring friends over to the house.

All of these people are aware that something is wrong. However, each person is using a form of *denial* to avoid directly confronting the truth of the matter. The various forms this denial takes include:

Rationalizing: The behavior is explained by focusing on possible causes for it other than alcoholism/drug addiction. The physician as well as his spouse, staff, colleagues, and children blame his drinking on stress, marital discord, anxiety, insomnia, etc.

Minimizing: Each significant person in the physician's life has convinced himself or herself that the problem is not *that* bad or that it is likely to take care of itself.

Moralizing: Many people have been taught to think of the abuse of alcohol and other drugs as a moral issue, an indication of lack of good character or willpower. In this so-called moral model, good people do not develop the drinking problems or become dependent on drugs. Because they see the physician as a good man, his friends, colleagues, and family members do not believe that *he* could be an alcoholic/addict. They feel ashamed and embarrassed for him, rather than recognizing that he is *sick* and in need of treatment.

Self-blaming: His wife, his secretary, and others believe that somehow they are at fault, that they should be able to control or put a stop to his unhealthy behavior. However, since what they are seeing are the signs of a progressive disease, this is not a realistic expectation.

Other barriers

In addition to denial, there are other barriers to identifying the problem and getting help for the physician. For instance, he is a skilled physician and a kind, caring man. No one wants to do anything to get him into trouble or create a problem where none exists. Also, everyone is afraid →

"No one wants to do anything to get him into trouble or create a problem where none exists. Also, everyone is afraid of how he might react if confronted."

of how he might react if confronted. What if he becomes angry? He might leave the family, fire the staff members, discontinue the friendship, send his referrals elsewhere, or sue someone.

No single individual knows the "whole story," and family members, colleagues, and others are not aware of the signs and symptoms of alcohol and drug addiction. Finally, no one knows the effective way to help a physician who is becoming impaired. Many medical professionals believe that, once a physician gets "hooked" on drugs and/or alcohol, the situation is hopeless—his career is over.

Therefore, everyone continues the struggle to cover up, ignore, compensate for, or explain away the progressive dysfunction—to do all the wrong things for the right reasons—a process known as *enabling*.

"Many medical professionals believe that, once a physician gets 'hooked' on drugs and/or alcohol, the situation is hopeless—his career is over."

A diagnosis of chemical dependency can be made only with a comprehensive evaluation of the physician by a practitioner with special training and experience in addiction medicine and professional impairment. However, several characteristic signs and symptoms can alert colleagues, coworkers, and family members to the likelihood that a problem exists and needs to be address:

- a noticeable change in behavior from previous familiar patterns;
- irritability, angry outbursts;
- deterioration in grooming, hygiene;
- withdrawal from family, community, and professional activities;
- lateness, unexplained absences, missed appointments;
- unavailability, "Locked-Door Syndrome";
- loss of compassion, empathy;
- multiple physical complaints and illnesses; and/or
- poor charting, delinquent records, increased illegibility of handwriting.

In most cases, these signs and symptoms preceed by months or even years the development of more obvious indicators of trouble, such as:

- odor of alcohol on the breath at the office or hospital;
- embarrassing social situations due to intoxication;
- auto crashes, arrests for driving under the influence;
- excessive drug orders for office use, missing samples from office, hospital; and/or
- inappropriate orders, abusive behavior toward patients, staff.

When drug and/or alcohol abuse is suspected in a physician, action must be taken as soon as possible to provide intervention and treatment. The disease of chemical dependency is progressive and potentially fatal without treatment. With appropriate recognition, treatment, and continuing care, physicians have an excellent prognosis for recovery. In most physician health programs, over 85 percent of referred addicted physicians are able to continue or resume practice successfully. Without help, most continue to experience progressive impairment of personal and professional function.

Resources

There are a number of resources available to help physicians who have developed chemical dependency. Many hospitals have or are in the process of developing medical staff health committees which can provide confidential assistance and referral to members of that hospital's staff. Information and assistance may also be available through some county medical societies.

The Physicians' Health Program (PHP) of the State Society's Educational and Scientific Trust assists Pennsylvania physicians in recovering from alcoholism, drug dependency, and other forms of personal and professional impairment. The PHP staff is available to discuss in confidence concerns about a physician who may be experiencing this type of problem. To reach the PHP, call (717) 558-7750.

Since most colleagues, family members, and other concerned persons are not experienced in recognizing and addressing these issues, it is valuable to be able to talk over the details with a professional who can help to assess the information and discuss options for effective intervention.

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NEW RETIREMENT PLAN LIMITS CALL FOR TIMELY PLANNING

The 1993 Revenue Reconciliation Act recently passed by Congress includes a new retirement plan limit that reduces the limit on an individual's compensation for determining the plan contribution for his or her benefit. The new, lower limit means that many doctors must decide whether or not to increase their funding percentages in order to continue putting into retirement savings the maximum amount permitted each year.

The old limit of $235,840 allowed many doctors to reach the maximum $30,000 allocation in a single defined contribution retirement plan (typically a profit-sharing plan) by funding at a level just over 12.7 percent of pay. "Integrating" a plan with Social Security meant that lower-paid employees could be funded at lower levels of around eight percent of pay.

Now, with the maximum contribution based on $150,000 of compensation, a practice must increase its contribution percentage to reach the same contribution of $30,000. In most plans, (again "integrating" with Social Security) this means increasing the staff funding percentage to approximately 16 percent of pay.

Planning for 1994

The $150,000 limitation takes effect for plan years starting in 1994, so now is the time to analyze your contribution situation. According to the law, changes made throughout the year are considered effective as of January 1994, as long as they do not result in a reduction or cut-back of existing benefits. However, should you elect to increase funding levels, you will need sufficient time to amend your practice retirement program, provide the required notices to your employees, and satisfy other requirements mandated by retirement plan and tax laws.

Many practices will actually need to set up a second retirement plan if they are now maintaining just one plan. The decision of what course to take can be made by comparing the increased staff costs if the plan is fully funded with the income taxes on the money if the extra dollars are paid to the doctor(s) in the form of additional salary/bonus.

Consider the options

Consider, for example, a group of three physicians, each earning over $200,000 and maintaining a single profit-sharing plan. Based on the new compensation cap of $150,000, the maximum amount that may be funded into the plan for each doctor is $22,500 (15 percent of $150,000). Assume that the practice maintains a staff of six employees who are paid compensation totaling $120,000, and that before the change in the law, it cost $9,600 in staff contributions in order to contribute $30,000 for each doctor. The doctors now need to decided whether it makes sense for the practice to pay another $9,600 (8 percent) in staff funding so that each doctor can continue to contribute at the $30,000 level.

The chart below illustrates the options of increasing funding versus no increase at all. In this example, increasing the funding percentage is clearly advantageous. By keeping the percentage equal to the percentage level before the change in the law, each doctor would pay an extra $4,494 in tax. This is based on a combined federal and state rate of 42 percent on the extra salary/bonus.

However, by increasing the funding percentage, the extra cost per doctor for staff funding is only $3,200 (total extra funding of $9,600 divided by three). Even by doubling the staff funding percentage, the physicians are still ahead of the game tax-wise—$4,494 per doctor versus $3,200 per doctor.

Two additional factors support the decision to increase the funding percentage. One is that earnings in the plan compound on a tax-deferred basis—if the extra dollars are taken as salary/bonus and invested in taxable vehicles, tax deferral is lost. The second is the intangible benefit that the doctors create by increasing the staff retirement percentage (employee "goodwill").

Each practice's retirement program obviously needs to be analyzed on an individual basis. In some cases, depending on the goals of the practice's owners, the size of the staff payroll, and the amounts already accumulated for retirement by the doctors, it may be advantageous to maintain current levels of funding percentages. Before making any major changes, be sure to review these issues and examine your specific circumstances with your retirement plan advisor.

The contributing author, Joseph W. Gallagher, JD, LLM, is an attorney with The Health Care Group, a practice management consulting firm based in Plymouth Meeting.

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No Increase in Funding Percentages

Doctors' Retirement Accounts	Doctors' Extra Salary/Bonus	Assume 42% Federal and State Tax on Extra Salary/Bonus	After Tax Amount
Dr. A $22,500	$7,500 + 3,200 = $10,700	$4,494	$6,206
Dr. B $22,500	$7,500 + 3,200 = $10,700	$4,494	$6,206
Dr. C $22,500	$7,500 + 3,200 = $10,700	$4,494	$6,206

Increase in Funding Percentages
Staff Retirement Accounts

Doctors' Retirement Accounts	Salary	8%–Old Law	16%–New Law
Dr. A $30,000	D-$30,000	$2,400	$4,800
Dr. B $30,000	E-$30,000	$2,400	$4,800
Dr. C $30,000	F-$20,000	$1,600	$3,200
	G-$15,000	$1,200	$2,400
	H-$15,000	$1,200	$2,400
	I-$10,000	$ 800	$1,600

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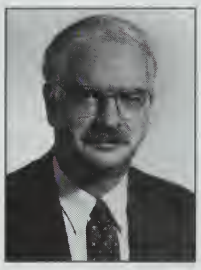
1994 SPRING ASSEMBLY

BUILDING ALLIANCES, COPING WITH THE FUTURE

Two years into the health system reform debate, we are still uncertain what the future holds for physicians and their patients. To prepare members to more effectively participate in the ongoing reform debate and cope with coming changes, the Society's annual Spring Assembly will focus on "Forging Alliances...Assuring Your Future." The assembly will be held April 19 and 20, 1994, at the Harrisburg Hilton and Towers.



Dr. Corlin

The Society's Spring Assembly Committee has scheduled a number of nationally known speakers to address the theme. Richard F. Corlin, MD, vice speaker of the AMA House of Delegates and immediate past president of the California Medical Association, will explore the future of health care in the keynote address. According to the committee, Dr. Corlin was chosen to open the assembly, because: "To plan for the future, we must first have a better idea what the future holds in store."

Dr. Corlin's perspective is based on his own experience as a practicing gastroenterologist and from insights gained through his national medical leadership role. His participation at the Forum on Health System Reform at the Society's 1992 Annual Business Meeting was well received.

A high-ranking official in the Clinton administration—promised by the Democratic National Committee—will then discuss the future of health system reform as seen by the White House, and Jennifer James, PhD, a cultural anthropologist, will discuss ways physicians confront and respond to change.

Thomas M. Reardon, Esq., one of the most popular presenters at last year's Leadership Conference, will conclude the afternoon with "Alliances with Health Care Professionals." Reardon, who works with Mintz, Levin in Boston, will discuss his experiences in assisting physicians in developing relationships with hospitals, financing entities, and other physician groups.

Following the formal presentations, physicians will have the opportunity to meet in smaller groups with Dr. Corlin and the other speakers for questions, discussion, and debate.

Tools for building alliances

Keeping with the themes of building alliances and assuring the future, the Spring Assembly is offering "Tools for Building Alliances" through six workshops scheduled Wednesday morning. Workshops include:

- "Computers Made Easy"—An overview the basics of personal computers and the growing role PCs are playing in the health care system.
- "PHO...Friend or Foe?"—"Nuts and bolts" considerations and ramifications of establishing various medical staff networks.
- "Financial Planning in the Changing Environment"—Designed for HMSS representatives and young physicians, focuses on repayment of educational debts, buying a home, buying insurance, establishing an investment plan, and saving for retirement.
- "Winning Approaches to Your Legislator and the Public"—Practical information and training on how to be more effective when talking to elected government officials and the public.
- "Difficult Decisions for Patients and Their Families"—How to talk to patients and their families about medically futile care and other ethical considerations raised by health system reform.
- "Contracting with Managed Care Organizations"—An overview of what physicians should ask for when entering into contractual arrangements.

To register

Deadline for registrations is March 18. Registration fees are: $65 for Society members, $30 for residents, and $100 for nonmembers; medical students may register free of charge. Participants are eligible for 7.5 hours of Category 1 continuing medical education (CME) credit. For registration materials and information, call the Society's Department of Member Communications at (800) 228-7823 or (717) 558-7750.

CLINICAL DECISION MAKING FOCUS OF HMSS SEMINAR

How do physicians and hospital medical staffs remain competitive in an era of downsizing, managed care, and prospective reimbursement? How can they demonstrate quality results and still keep their practices and hospital lean, yet retain the rewards of improved efficiency?

Those are the questions the new, half-day seminar, "Improving Cost-Effective Clinical Decision Making," will answer the evening before the Society's Spring Assembly.

Hospital medical staff leaders—including physicians directing quality assurance, utilization review, risk management, and cost containment—are invited to attend this train-the-trainer experience in which participants will receive materials and skills to help them train their own medical staffs in the most efficient use of hospital resources.

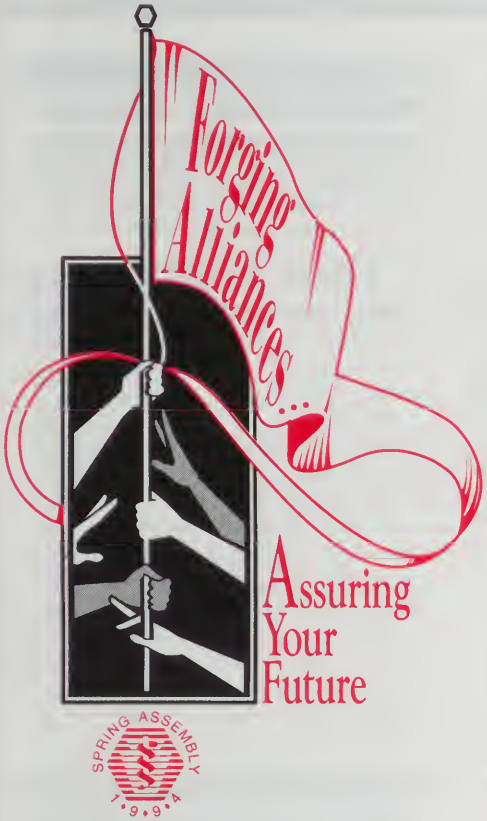
Speakers will include:

- Toni M. Casale, DO, director of outcomes and assessment, Philadelphia College of Osteopathic Medicine, Philadelphia;
- Lee H. McCormick, MD, chairman, of the AMA-HMSS;
- David B. Nash, MD, MBA, director of health policy and clinical outcomes, Jefferson Medical College, Philadelphia; and
- David J. Shulkin, MD, director of clinical outcomes assessment and quality management, University of Pennsylvania Medical Center, Philadelphia.

The seminar—cosponsored by the Society's HMSS and The Scientific and Educational Trust's Institute for Physician Leadership, and supported in part by an educational grant from the Upjohn Company—begins at 4:00 p.m. on April 18 at the Hilton and concludes at 8:00 p.m. Four hours of Category 1 CME credit have been requested.

The cost of the seminar, which includes the evening meal, is $130 for Society members and $165 for nonmembers. Medical staffs and hospitals are eligible for group discounts when more than one physician attends from the same hospital or health care organization.

For further information, call (800) 228-7823, extension 461. Registration deadline is March 31.



Pennsylvania Medical Society

Spring Assembly April 19-20, 1994

Harrisburg Hilton and Towers

Tuesday, April 19

8:30 a.m.-11:30 a.m. ***Society–HMSS 20th Assembly Meeting***

11:30 a.m.-1:30 p.m. ***HMSS–Spring Assembly Joint Luncheon***

1:30 p.m. ***Spring Assembly Opening and Welcome***

Keynote Address: **Richard F. Corlin, MD**

This portion of the program is supported in part by a grant from the Raymond C. Grandon, MD, and Doris N. Grandon Fund of The Educational and Scientific Trust of the Pennsylvania Medical Society.

Plenary Sessions

"What is the Future of Health System Reform?"

"Dealing with the Future", Jennifer James, PhD, cultural anthropologist

"Alliances with Health Care Professionals", Thomas M. Reardon, Esq., of Mintz, Levin, in Boston

Break-Out Sessions

6 p.m. ***Reception***

7 p.m. ***PAMPAC Dinner***

Entertainment by the popular Capitol Steps, former Capitol Hill employees whose witty send-ups of Washington people and events have been showcased in three national television specials, eleven albums, and 300 performances a year throughout the United States.

Wednesday, April 20

7 a.m. ***Breakfast*** **Martin A. Murcek, MD:** President's Address

Presentation of the first annual Pennsylvania Medical Society Physician Volunteer Award

8:15 a.m.-noon ***Workshops—Tools for Building Alliances (Choice of 3)***

Computers Made Easy: A discussion of the basics of personal computers and the growing role PCs are playing in the health care system, presented by Edward H. Dench Jr., MD, of the Society's Board of Trustees.

PHO . . . Friend or Foe? Developed in cooperation with the Hospital Medical Staff Section Governing Council and presented by KPMG Peat Marwick.

Financial Planning in the Changing Environment: Presented by AMA Investment Advisors, Inc.

Winning Approaches to Your Legislator and the Public: Practical information and training on how to be more effective when you talk about health system reform and other issues with your elected government officials and with the public.

Difficult Decisions for Patients and Their Families: Stuart Youngner, MD, will discuss how to talk to patients and their families about medically futile care and other ethical considerations raised by health system reform.

Contracting with Managed Care Organizations: Alice G. Gosfield, Esq., a health care law specialist from Philadelphia and a popular speaker at past Society meetings, discusses what physicians should ask for when entering into contractual arrangements.

The Pennsylvania Medical Society is accredited by the Accreditation Council for Continuing Medical Education to sponsor medical education for physicians.

The Pennsylvania Medical Society has designated this continuing medical education activity for 7.5 hours in Category 1 of the Physicians Recognition Award of the American Medical Association and the Pennsylvania Medical Society membership requirements.

All faculty participating in continuing medical education programs sponsored by the Pennsylvania Medical Society are expected to disclose to the program audience any real or apparent conflict(s) of interest related to the content of their presentation(s).

See the March issue of* Executive Report *for the registration form!

SOCIETY'S ANTI-SMOKING EFFORTS RECOGNIZED

The Society continues its partnership in the Pennsylvania Department of Health's Youth Against Tobacco (YAT) campaign, which encourages teenagers not to smoke by asking them to take a pledge and providing them with anti-smoking information. Other partners in the program include the state Department of Education and the state chapter of the American Cancer Society.

During the 78th Annual Pennsylvania State Farm Show in Harrisburg in January, Society staff volunteers served at a YAT informational booth, where tens of thousands of promotional buttons, posters, and other materials were distributed, and thousands of young people signed pledges not to use tobacco products.

Statewide, campaigns have been conducted by more than 150 organizations, including schools and youth organizations, in 45 of the state's 67 counties. Currently, television and radio spots are being aired to promote teenage anti-tobacco behaviors.

In addition, project materials have been requested by people in Ireland, Africa, and Canada, and in New York, New Jersey, Maryland, the District of Columbia, Virginia, Florida, and West Virginia. The materials have also been shared with the Centers for Disease Control and Prevention.

The project has been recognized by numerous organizations: It was presented at the fall 1993 annual meeting of the American Public Health Association in San Francisco, and the radio "rap" commercial won first place in the Central Penn Ad Federation ADDY competition and received a 1993 Gold Excellence Award for a radio public service announcement from the National Public Health Information Coalition for Communications.

For more information about the program or the Society's involvement, call the Division of Communications and Public Affairs at (800) 228-7823 or (717) 558-7750.

NEW MANAGED CARE SYSTEM FORMING IN PHILADELPHIA

Graduate Health System and Independence Blue Cross, both in Philadelphia, have agreed to merge their for-profit operations into a new managed care subsidiary under Independence Blue Cross.

According to Independence Blue Cross President G. Fred DiBona Jr., "The result will be the creation of a vertically integrated delivery system offering a comprehensive package of health care benefits in a managed care environment which delivers quality care at the best price possible." He adds that the only "real way" to control costs and assure quality is "at the point of service delivery by providers and practitioners."

Graduate Chairman and Chief Executive Officer Harold Cramer says the proposed merger is a "logical" move for the health system, which currently includes seven hospitals, an HMO, and other health businesses. He explains the merger will expand services available to Graduate patients, while allowing them to stay within the Graduate system.

The *Philadelphia Inquirer* reported that the proposed system "closely mirrors many of the reforms envisioned by the Clinton health plan." But DiBona says, "Aside from whatever may happen in Washington or Harrisburg, health care reform in the private market is happening now."

COUNTY NEWS

Pat Myers (left) and Brigitte Davidson (right) were two of 75 participants at a living will seminar sponsored recently by the Montgomery County Medical Society (MCMS). The seminar emphasized that a living will "ensures you dignity if you are ill, can speak for you when you cannot, and can save you and your heirs money." Statistics show that approximately 80 percent of Pennsylvanians do not have a living will. Also pictured in the middle (left to right) are seminar speakers Leonard Frank, MD, and Barbara Zulich, Esq.

MEDICAL SCHOOL NEWS

WOMEN'S HEALTH MEDICAL EDUCATION GROUP FORMED

The Medical College of Pennsylvania (MCP), Philadelphia, and the American Medical Women's Association (AMWA) have joined forces to create the National Academy on Women's Health Medical Education, the first group nationally to focus specifically on women's health in medical education.

The mission of the academy is "to blend women's health into every facet of medical education from medical student teaching, to the residencies, to the halls of academia, and to physicians already in practice." The group will "propose strategies and analyze their effectiveness with two goals in mind: 1) the successful inclusion of women's health education into the majority of medical school and residency curricula; and 2) the consequent delivery of appropriate, high-quality health care to all women."

Leaders from other medical schools and organizations with interest or expertise in women's health and women's history have been invited to join the academy, which will hold its first meeting on March 21 at MCP. For further information, call (215) 842-4522.

SPECIALTY SOCIETY NEWS

ORTHOPEDIC SOCIETY PLANS SPRING MEETING

The Pennsylvania Orthopedic Society will hold its Spring 1994 meeting, "Total Knee Arthoplasty: Advances, Complications, and Outcomes," on April 20-23 at the Boca Raton Resort and Club, Boca Raton, Florida. The meeting offers 12.5 hours of Category I CME credit. For more details or to register, call (717) 558-7750, extension 447.

OTOLARYNGOLOGISTS TO DISCUSS SCIENTIFIC ISSUES

Physicians are invited to attend the annual scientific meeting of the Pennsylvania Academy of Otolaryngology-Head and Neck Surgery to be held June 16-18, 1994, at the Hotel Hershey.

Fred J. Drucker, MD, professor and chairman of otolaryngology-head and neck surgery, Louisiana State University Medical Center,

Shreveport, Louisiana, will be the guest of honor. In-depth panels will focus on facial plastic and reconstructive surgery and surgery of the thyroid and parathyroid glands. For further information, call Al Walter at (610) 775-3298.

REFORM, CLINICAL TOPICS FOCUS OF ALLERGY MEETING

Allergists will have the opportunity to discuss health system reform at the Pennsylvania Allergy Association's 46th Annual Meeting, scheduled the mornings of June 24-26, 1994, at the Hotel Hershey. Clinical topics to be covered include upper airway, asthma, immunotherapy, anaphylaxis, and food allergies.

The association has applied for 12 hours of Category 1 CME credits for the three-day program. A registration fee of $150 will be charged to nonmembers. For more information, call (717) 558-7750, extension 468.

ALLIANCE NEWS

AMA REP TO DISCUSS REFORM AT PMSA CONFLUENCE

AMA Vice President of Legislative Affairs Ross Rubin, JD, will discuss health system reform at the Pennsylvania Medical Society Alliance (PMSA) confluence, to be held April 12-15, 1994, at Toftrees Hotel Resort and Conference Center, State College.

Mr. Rubin, who has been with the AMA since 1976, is responsible for federal legislation and AMA Council on Legislation activities. He will offer an overview of current reform activities, as well as AMA positions on reform.

Also scheduled:

- Patricia Dolence, an interaction consultant from Johnstown, will present "Understanding People and Predicting Their Behavior," a two-hour seminar offering ideas to get people to work together, minimize potential conflicts, recognize "motivators/satisfiers," convey messages essential to gaining cooperation, and realize the full impact of nonverbal communication.
- Timothy Murphy, PhD, a clinical psychologist from Pittsburgh, will discuss TV violence.
- William J. Evans, PhD, director of the Noll Laboratory for Human Performance Research, and professor of nutrition and applied physiology, Penn State, State College, will present, "Beating the Clock: Can We Slow the Aging Process with Exercise."
- Eileen Plundo, RN, a clinical case manager from Greensburg, will discuss managing the physician's office in today's environment.

For additional program or registration information, call PMSA at (800) 228-7823.

PMSLIC ISSUES SEMI-ANNUAL CLAIMS STATISTICS REPORT

The Pennsylvania Medical Society House of Delegates Resolution 86-17 requires that the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) report certain claims statistics to the House of Delegates on a semi-annual basis.

In response to this resolution, PMSLIC published the first semi-annual report in the September 1987 PENNSYLVANIA MEDICINE. The data included in the following tables is an update of PMSLIC's claims experience as requested by the resolution. →

TABLE 1: Number of cases in which a physician is joined as an additional defendant by a hospital or physician

Since beginning tracking joinder data on April 7, 1987, 119 PMSLIC insureds were joined by other parties through December 1993, as follows:

PMSLIC Insured Joined By:	Number of Times:
Hospital	56
Other Physician	30
Nursing Home	3
Commercial Business	5
Plaintiff	4
Pharmacy/Pharmacist	9
Manufacturer	1
Drug Company	3
Other	8
TOTAL	**119**

During the same period, PMSLIC joined 21 other parties, as follows:

Party Joined By PMSLIC:	Number of Times:
Hospital	2
Physician	10
Drug Company	1
Manufacturer	4
Other	4
TOTAL	**21**

TABLE 2: Number of claims and suits filed by specialty from January 1, 1978-December 31, 1993*

Specialty	Total Claims and Suits	Specialty	Total Claims and Suits
Allergy	18	Pathology	48
Anesthesiology	447	Pediatrics	400
Cardiac Surgery	31	Plastic Surgery	364
Cardio-Thoracic Surgery	62	Preventive Medicine	1
Cardio-Vascular Surgery	134	Proctology	12
Cardio-Vascular & Thoracic Surgery	128	Psychiatry	69
Cardiology	314	Pulmonary Diseases	1
Colon-Rectal Surgery	1	Radiology	620
Dermatology	128	Rehabilitation/Physiatry	114
Emergency Medicine	360	Rheumatology	10
Family Practice	702	Thoracic Surgery	71
Gastroenterology	44	Urology	247
General Practice	729	Vascular Surgery	34
General Surgery	1,612	Vascular/Thoracic Surgery	7
Geriatrics	1	Physicians NOC	94
Gynecology	72	***Other Practitioners***	
Hematology	2	Clinical Psychologist	1
Hematology/Oncology	8	Nurse Anesthetist	19
Industrial Medicine	17	Nurse Midwife	3
Infectious Diseases	6	Nurse Practitioner	2
Internal Medicine	1,700	Physician's Assistant	6
Nephrology	6	Physiotherapist	1
Neurology	147	Registered Nurse	7
Neurosurgery	388	Surgical Technician	4
Nuclear Medicine	3	X-Ray Technician	1
OB/GYN	1,597	Other Practitioner	1
Oncology	14		
Ophthalmology	344	Corporate Liability	1,096
Orthopedics	23	Partnership Liability	54
Orthopedic Surgery	1,737		
Otolaryngology	285	**GRAND TOTAL**	**14,347**

** Claims and suits filed during this period resulted from policy years 1978-1993. PMSLIC's limit of liability is $100,000 per incident for policy years 1978-1982, $150,000 for 1983, and $200,000 for 1984-1993.*

Keep in mind that the specialty totals are affected in part by the number of PMSLIC insureds in each specialty. In addition, some specialties are relatively new rating classifications and were not in existence for the entire time period represented.

TABLE 3
Breakdown of PMSLIC Claims and Suits Filed by Specialty
January 1, 1978–December 31, 1993

Physician Specialty	# Open C & S	Closed Settlement No Loss Payment # C & S	Closed Settlement No Loss Payment Avg Exp Pmt	Closed Verdicts No Loss Poyment # C & S	Closed Verdicts No Loss Poyment Avg Exp Pmt	Closed Settlements With Loss Payment # C & S	Closed Settlements With Loss Payment Avg Loss Pmt	Closed Settlements With Loss Payment Avg Exp Pmt	Closed Verdicts With Loss Payment # C & S	Closed Verdicts With Loss Payment Avg Loss Pmt	Closed Verdicts With Loss Payment Avg Exp Pmt
Physician Specialties											
Allergy	9	5	$ 4,559	0	$ -0-	4	$35,625	$ 2,720	0	$ -0-	$ -0-
Anesthesiology	73	183	3,907	18	21,473	170	30,829	4,350	3	74,333	11,884
Cardiac Surgery	7	19	4,504	3	18,628	2	26,250	498	0	-0-	-0-
Cardio-Thorocic Surg.	16	32	5,169	3	28,287	11	79,091	20,860	0	-0-	-0-
Cardio-Vasc. Surg.	24	57	3,928	7	38,878	43	70,973	10,123	3	166,667	36,336
Cardio-Vascular & Thoracic Surgery	49	55	5,107	4	23,161	17	88,412	14,916	3	72,678	41,016
Cardiology	146	140	5,599	1	28,255	26	80,151	11,364	1	1,750	11,857
Colon-Rectal Surgery	0	1	656	0	-0-	0	-0-	-0-	0	-0-	-0-
Dermatology	25	66	3,865	9	24,756	27	34,380	8,427	1	24,000	32,485
Emergency Medicine	56	174	4,813	27	22,337	91	56,918	8,450	12	30,283	12,008
Family Practice	250	281	5,042	29	26,605	137	86,968	10,044	5	87,395	21,068
Gastroenterology	11	21	3,244	1	9,577	11	51,659	13,719	0	-0-	-0-
General Practice	120	334	4,408	41	30,733	228	61,451	9,222	6	39,942	16,953
General Surgery	273	696	5,327	111	24,666	507	69,327	9,801	25	98,440	27,491
Geriatrics	0	1	8,658	0	-0-	0	-0-	-0-	0	-0-	-0-
Gynecology	12	30	4,420	2	26,150	27	68,019	9,090	1	3,289	2,388
Hematology	1	1	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Hematology/Oncology	6	2	1,318	0	-0-	0	-0-	-0-	0	-0-	-0-
Industrial Medicine	2	10	2,759	1	6,164	3	133,500	22,949	1	4,000	5,241
Infectious Diseases	5	1	18,589	0	-0-	0	-0-	-0-	0	-0-	-0-
Internal Medicine	481	799	6,480	76	26,295	326	71,888	11,751	18	75,102	41,384
Nephrology	4	2	9,434	0	-0-	0	-0-	-0-	0	-0-	-0-
Neurology	34	90	6,191	6	20,220	16	78,531	13,196	1	50,000	755
Neurosurgery	70	194	6,810	25	38,277	91	76,267	17,893	8	118,889	28,671
Nuclear Medicine	0	2	2,247	0	-0-	1	60,000	75	0	-0-	-0-
OB/GYN	357	656	5,615	89	30,213	459	80,738	10,540	36	72,535	28,440
Oncology	5	8	236	0	-0-	1	4,000	1,948	0	-0-	-0-
Ophthalmology	79	176	3,293	21	23,624	66	73,656	7,562	2	119,523	21,562
Orthopedics	1	13	4,941	2	20,066	7	27,429	7,373	0	-0-	-0-
Orthopedic Surgery	232	846	5,001	139	26,946	497	62,277	9,685	23	83,815	29,301
Otolaryngology	37	141	4,742	27	22,659	72	55,551	9,590	8	67,115	34,453
Pathology	18	18	7,213	2	52,840	10	82,150	11,283	0	-0-	-0-
Pediatrics	131	163	6,458	26	32,408	75	92,289	14,785	5	134,710	40,221
Plastic Surgery	111	141	4,046	22	22,834	83	41,046	7,551	7	64,367	34,916
Preventive Medicine	0	1	21,584	0	-0-	0	-0-	-0-	0	-0-	-0-
Proctology	1	3	8,636	0	-0-	8	130,000	14,802	0	-0-	-0-
Psychiatry	19	32	7,500	6	30,838	12	60,858	15,189	0	-0-	-0-
Pulmonary Diseases	0	1	1,571	0	-0-	0	-0-	-0-	0	-0-	-0-
Radiology	158	327	5,273	13	36,812	114	59,427	9,808	8	57,080	20,643
Rehabilitation/Physiotry	54	52	6,556	4	19,065	4	125,625	17,190	0	-0-	-0-
Rheumatology	6	3	6,836	1	15,936	0	-0-	-0-	0	-0-	-0-
Thoracic Surgery	8	41	8,367	0	-0-	21	70,835	8,373	1	83,718	42,612
Urology	50	106	5,168	18	23,189	68	49,175	8,469	5	90,297	35,727
Vascular Surgery	11	14	6,008	2	34,096	7	79,643	18,351	0	-0-	-0-
Vasc. & Thorocic Surg.	4	3	1,870	0	-0-	0	-0-	-0-	0	-0-	-0-
Physicians NOC	16	45	5,704	8	25,859	23	33,188	4,951	2	181,392	70,304
Other Practitioners											
Clinical Psychologist	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Nurse Anesthetist	3	6	3,852	0	-0-	10	19,730	1,044	0	-0-	-0-
Nurse Midwife	0	1	18,793	0	-0-	2	62,728	4,516	0	-0-	-0-
Nurse Practitioner	1	0	-0-	1	6,265	0	-0-	-0-	0	-0-	-0-
Physician's Assistant	4	1	1,425	0	-0-	1	150,000	83	0	-0-	-0-
Physiotherapist	0	0	-0-	0	-0-	1	5,000	-0-	0	-0-	-0-
Registered Nurse	3	3	2,989	0	-0-	1	7,500	134	0	-0-	-0-
Surgicol Technicion	3	1	6,813	0	-0-	0	-0-	-0-	0	-0-	-0-
X-Roy Technician	0	1	1,484	0	-0-	0	-0-	-0-	0	-0-	-0-
Other Practitioner	0	0	-0-	0	-0-	1	4,000	2,923	0	-0-	-0-
Corporate Liability	615	382	5,090	45	18,792	47	80,212	11,573	7	112,407	20,521
Partnership Liability	30	18	5,277	4	20,486	2	53,500	2,704	0	-0-	-0-
GRAND TOTALS	**3,632**	**6,399**	**$5,313**	**794**	**$26,544**	**3,330**	**$66,789**	**$10,013**	**192**	**$80,253**	**$28,468**

** Claims and suits filed during this period resulted from policy years 1978-1993. PMSLIC's limit of liobility is $100,000 per incident for policy years 1978-1982, $150,000 for 1983, and $200,000 for 1984-1993.*

Keep in mind thot the specialty totols are affected in part by the number of PMSLIC insureds in each speciolty. In oddition, some speciolties are relatively new rating classifications and were not in existence for the entire time period represented.

Please note: Though previous reports have included only five years of claims, to more accurately reflect PMSLIC's experience, the tables are being expanded this year to include all claims and suits indexed against PMSLIC insureds since the company's inception in 1978.

Table 1 (page 45): Joinders—includes PMSLIC physicians joined by other parties and other parties joined by PMSLIC.

Table 2 (page 45): Number of claims and suits filed by specialty, January 1, 1978, to December 31, 1993.

Table 3 (above): Cost of claims and suits filed by specialty, January 1, 1978, to December 31, 1993.

Direct any questions or comments about this material to Jane L. Conley, Director of Medical Research and Statistics, PMSLIC, P.O. Box 8375, Harrisburg, PA 17105-8375, (717) 558-7500, extension 501.

QUARTERLY REPORT OF HOUSE AVAILABLE

In accordance with Resolution 92-27 of the House of Delegates, the quarterly report on actions of the House is now available from the State Society. The report is provided to members to enable them to respond to and participate in upcoming House activities. To request a copy, call (800) 228-7823, extension 403.

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SOCIETY COMMENTS ON DPW MANAGED CARE PLAN

The State Society recently outlined some reservations voiced by physicians regarding a proposed managed care plan for Philadelphia and the five surrounding counties. The comments were sent in late 1993 to the Pennsylvania Department of Public Welfare (DPW).

According to the December 11, 1993, issue of *Pennsylvania Bulletin*, the new managed care program is designed to replace the Health Insurance Organization (HIO) plan previously in place in the Philadelphia area, and would be implemented in October 1994. The proposal creates three separate "districts," splitting Philadelphia and aligning each of the areas with adjacent counties. State-licensed health maintenance organizations (HMOs) could bid to be a certified plan for the districts, and DPW could approve between two and six plans to operate within each district.

The Society supports the basic goal of the program—pairing Medical Assistance (MA) patients with primary care physicians for coordination and management of health care. However, the Society is concerned that "access to quality health care may be less available to the MA patients as a result of these initiatives."

The letter also states that "any initiative that discourages physicians from participating by increasing paperwork or interrupting the patient-physician relationship will not succeed." Instead, we believe more could be accomplished in encouraging physicians' participation by DPW initiatives such as adoption of a uniform claim form.

Further, the Society said the department "failed to involve [interested] parties in a meaningful dialogue during the planning stages" of the program, and requested "a more open involvement" of all parties—the MA patient, physicians and other health care providers, insurers, elected representatives, etc.—in the design and implementation of the program.

Among other areas of concern were plan marketing, medical service, provider enrollment, quality assurance, and utilization management issues. The Society is continuing dialogue with the department to further discuss specifics and will react to the request for proposal when it is circulated.

PETITION FILED FOR SINGLE STATEWIDE CHARGE LOCALITY

At the direction of the 1993 House of Delegates, the State Society in early February filed a petition with the Health Care Financing Administration (HCFA) requesting a single statewide charge locality for determination of Medicare payments to physicians.

HCFA has said it will consider changing a multi-locality state, such as Pennsylvania, to a statewide locality only if there is "overwhelming support" among state physicians. To date, only five states have been converted to a statewide locality; four states' petitions have been denied for lack of overwhelming support. The Society has received numerous letters—including copies of letters addressed to HCFA—from county societies, specialty societies, individual physicians, and others. Some support the move, and others oppose it.

Timeline

The Office of Payment Policy (OPP), the unit within HCFA responsible for reviewing statewide locality petitions, has advised the Society that the federal rule-making process applies to petitions for a statewide charge locality, and released the following timeline:

- An approved petition with information required by OPP (includes formal state medical society request, House resolution with vote count, list of number of actively practicing physicians in state by county and number that are state society members, and letters of support from local societies representing physicians who will experience decrease in reimbursement under proposed change) must be submitted to HCFA by early February 1994.
- If the petition fulfills all of OPP's requirements, the request for a statewide charge locality will be published as a proposed rule in the *Federal Register* in Spring 1994—with a 60-day public comment period.
- Once comments are reviewed, a decision will be made by OPP (for HCFA) as to whether a final rule will be published.
- A final rule would be published in Winter 1994, if HCFA decided to implement a statewide locality. HCFA has advised that the earliest implementation date is January 1995.

Watch for updates on movement of the petition throughout 1994. Direct any questions on the issue to the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

EFFORTS CONTINUE TO RESOLVE MEDICARE ISSUE

The Society continues efforts to resolve the Medicare clinical laboratory overpayment refund demand from Pennsylvania Blue Shield.

In early September 1993, approximately 1,600 physicians and labs were informed that they had been overpaid for outpatient clinical lab services under Medicare and that they had to refund the excess amounts. The Society immediately objected to the demand, which included a 13.635 percent interest rate to be imposed on amounts not paid within 30 days, and was successful in efforts to have the Health Care Financing Administration (HCFA) place a hold on the situation.

Currently, the Society is working with the AMA and other states involved to resolve the situation. The AMA House of Delegates adopted a resolution at its December interim meeting which addressed protection of physicians in similar situations.

CHAMPUS LIMITS BALANCE BILLING FOR NON-PAR DOCS

As of January 1, physicians who do not participate in the Civilian Health And Medical Program of the Uniformed Services (CHAMPUS) are limited to how much they can bill CHAMPUS patients. The program is the U.S. Defense Department's health benefits plan for military families who receive medical care from civilian hospitals and doctors.

According to the Department of Defense Appropriations Act of 1993, physicians who do not participate in the program may bill CHAMPUS patients no more than 115 percent of the CHAMPUS allowable charge for a particular service.

Providers who do not comply with the limit on charges could lose their status as authorized providers of care under the Defense Department program.

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Annual Mental Health Seminar
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April 22, 1994

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Wednesday
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Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

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HCQII: Local Cooperative Projects

Donald E. Harrop, MD

Last month, we discussed the major sources of cooperative projects under the Keystone Peer Review Organization's new Health Care Quality Improvement Initiative (HCQII). In this installment of our review of HCQII components, we go one step further, focusing on local PRO-initiated cooperative projects.

As we continue to look at the various components of the Health Care Quality Improvement Initiative (HCQII), it becomes clear that the success of this new peer review organization (PRO) direction depends upon how well cooperative projects are designed, developed, and completed. Of the two types of cooperative projects—local PRO-initiated and national—the major focus is on the local projects. Each PRO will analyze its own state data, plan the projects, initiate the necessary action, and measure the outcomes of the projects which result from PRO and provider collaborations.

Of course, these projects are conducted in accordance with guidance and requirements provided by the Health Care Financing Administration (HCFA). Because there has been little or no prior in-depth experience with a quality improvement program of this complexity, it is expected that the HCFA rules and requirements may change continuously as PROs gain experience, and provide feedback to HCFA central and regional offices.

As we discussed in last month's article, there are numerous sources of subjects for cooperative projects. The data analysis conducted by the PRO in the early stages is vital because lack of identification of aberrant patterns could cause an otherwise significant subject to be scrapped. Even subtle variations in the data must be recognized if the PRO is to develop meaningful projects.

It is also extremely important that during the designing of the project, provider input is incorporated as early as possible. This is essential since potential obstacles to implementation of action plans need to be addressed during the development stage. This allows the PRO to gain the willing participation of the providers and to refine the data analysis. It also facilitates acceptance of analytic results when presented to the providers.

Each project developed should address important issues in quality of care, utilization of services, and accuracy of data, and should have the potential to improve performance. It is a HCFA requirement that at least 50 percent of all cooperative projects must focus on quality issues.

"Each project developed should address important issues in quality of care, utilization of services, and accuracy of data, and should have the potential to improve performance."

Stringent statistical methods are employed when analyzing data, measuring outcomes, and determining sample size. The intended result is to identify possible clinical issues causing the variations, rather than merely establishing statistical explanations. The bottom line is to modify provider behavior if necessary, in a cooperative manner, in those situations where less than desirable outcomes have been routinely occurring.

The Keystone Peer Review Organization's first cooperative project should be completed this month. Another six PRO-initiated projects were in various stages of development at press time.

Dr. Harrop is president of the Keystone Peer Review Organization.

Commission Seeks Support for High-Quality School Health Education

The Society's Commission on Public Health is undertaking a project designed to assure that every child in Pennsylvania receives the benefits of a comprehensive, high-quality health education.

The Society's House of Delegates called for a mandate in Pennsylvania requiring all schools in the commonwealth to provide this to all students. The commission—realizing that Pennsylvania is not yet ready to accept such a mandate—plans to address the issue locally throughout the commonwealth.

In cooperation with the Pennsylvania School Health Education Coalition, the commission plans to encourage physicians and others to ask questions about the programs that exist in the schools in their communities. Through other coalition members, such as the American Cancer Society and the Pennsylvania PTA, the commission can provide contacts for like-minded individuals in the physician's community.

Also, the coalition is preparing a folder of information that includes a model school health program, information on education standards in Pennsylvania, how the school systems work, and information on coalition building.

The commission hopes that informal contacts between individuals will result in the creation of local coalitions dedicated to assuring that the schools in their communities provide quality, comprehensive health education to all students.

To be placed on the mailing list for additional information and the names of contacts in your area, call the Society's Department of Educational and Scientific Affairs at (800) 228-7823 or (717) 558-7750.

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OBITUARIES

Philip Berg, MD, *Bellaire, TX*
Jefferson Medical College of Thomas Jefferson University, 1938; age 81, died January 2, 1994. Dr. Berg was a general practitioner.•

Eugene F. Berkman, MD, *Beaver*
Temple University School of Medicine, 1938; age 84, died November 22, 1993. Dr. Berkman was an orthopedic surgeon.•

Anthony G.B. Borden, MD, *Rydal*
Harvard Medical School, 1938; age 80, died January 6, 1994. Dr. Borden was a radiologist.•

Harry B. Bower, MD, *Harrisburg*
Jefferson Medical College of Thomas Jefferson University, 1934; age 86, died December 18, 1993. Dr. Bower was a general practitioner.•

Andrew D. Bulkley, MD, *Green Valley, AZ*
Cornell Medical College, 1951; age 72, died December 8, 1993. Dr. Bulkley was a general/pediatric practitioner.•

Alexander Franco, MD, *Bellefonte*
New York University School of Medicine, 1935; age 82, died November 29, 1993. Dr. Franco was an obstetrician/gynecologist.•

Paul A. Hanlon, MD, *Kingston*
Jefferson Medical College of Thomas Jefferson University, 1940; age 80, died November 24, 1993. Dr. Hanlon was an obstetrician/gynecologist.•

Beryl Jaffe, MD, *Pompano Beach, FL*
University of Pennsylvania School of Medicine, 1940; age 78, died December 25, 1993. Dr. Jaffe was a psychiatrist.•

Robert J. Kurey, MD, *Lancaster*
University of Pittsburgh School of Medicine, 1955; age 63, died December 16, 1993. Dr. Kurey was a psychiatrist.•

William M. McNaugher, MD, *Zelienople*
University of Pennsylvania School of Medicine, 1924; age 95, died December 6, 1993. Dr. McNaugher was a psychiatrist.•

C.E. Miller, MD, *Lititz*
Temple University School of Medicine, 1937; age 84, died December 23, 1993. Dr. Miller was a general practitioner.•

James M. Miller, MD, *Montrose*
University of Pennsylvania School of Medicine, 1955; age 64, died November 26, 1993. Dr. Miller was an internist.•

Leon Rosenbaum Jr., MD, *Melrose Park*
Jefferson Medical College of Thomas Jefferson University, 1944; age 74, died December 15, 1993. Dr. Rosenbaum was an internist.•

Sam Schlesinger, MD, *Hazleton*
Jefferson Medical College of Thomas Jefferson University, 1938; died December 2, 1993. Dr. Schlesinger was a general practitioner.•

Charles A. Yetsconish, MD, *Belle Vernon*
University of Alabama School of Medicine, 1984; age 45, died November 25, 1993. Dr. Yetsconish specialized in physical medicine and rehabilitation.•

William J. Yevitz, MD, *Scranton*
Georgetown University Medical School, 1942; age 77, died December 5, 1993. Dr. Yevitz was a general practitioner.•

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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Dr. Casale

The Pennsylvania Medical Society Board of Trustees has appointed **Carl A. Sirio, MD**, Pittsburgh, as the Society's additional delegate to the Pennsylvania Health Care Cost Containment Council (PHC4) Data Systems Committee. Also, the board appointed **Toni S.M. Casale, DO**, Camp Hill, as additional delegate to PHC4's Education Committee.

Jody R. Piltz, MD, ophthalmologist, Scheie Eye Institute, Philadelphia, was awarded a $750,000 grant by the National Eye Institute of the National Institutes of Health. The grant supports an eight-year study to determine if medicine to reduce intraocular pressure will prevent or delay the onset of glaucoma damage in eyes with elevated intraocular pressure.

R. Barrett Noon, MD, director of surgery and chief of the service of plastic surgery, Bryn Mawr Hospital, was named a governor of the American College of Surgeons.

Lila Stein Kroser, MD, Philadelphia, was appointed to the Committee on Finance and Insurance of the American Academy of Family Physicians.

Kat Kolaski, MD, was appointed director of pediatric rehabilitation, Children's Rehabilitation Hospital, Philadelphia.

Penn State's College of Medicine at The Milton S. Hershey Medical Center and Lehigh Valley Hospital, Allentown, have signed an affiliation agreement to establish a formal relationship between the two health care institutions for the purpose of medical education, clinical research, and patient care.

The American Medical Writing Association awarded **H. Michael Zal, DO,** Bala Cynwyd, the Frances Larson Memorial Award for his article, "When Fatigue is Chronic," which appeared in the June 1992 issue of *Family Practice Recertification*.

Herbert E. Mandell, MD, Wyncote, chief of child adolescent psychiatry, Albert Einstein Medical Center and Belmont Center for Comprehensive Treatment, Philadelphia, has been elected president elect of the Regional Council of Child and Adolescent Psychiatry of Eastern Pennsylvania and Southern New Jersey.

Robert W. Colman, MD, director, Sol Sherry Thrombosis Research Center, Temple University School of Medicine, Philadelphia, received the Distinguished Career Award from the International Society on Thrombosis and Haemostasis.

Victor M. Bove, DO, chief of clinical services, Wernersville State Hospital, has been inducted as a fellow of the American College of Physician Executives.

Penn State's Milton S. Hershey Medical Center has named **Bruce H. Hamory, MD,** associate dean for clinical affairs.

Dr. Axelrod

Lawrence S. Axelrod, MD, was appointed medical director of both Moyer Packing, Souderton, and Fleer, Inc., Philadelphia.

David J. Eskin, MD, chief of staff, Abington Memorial Hospital, has received the 1993 Frobese Day Award in recoginition of his distinguished service and contribution to furthering medical education at the hospital.

Herbert E. Segal, MD, previously principal clinical coordinator/ corporate medical director, KePRO, was appointed executive vice president of operations and medical affairs at CHP-The Medical Group, New Hyde Park, New York.

Barry W. Rovner, MD, director, Wills Geriatric Psychiatry Program, Wills Eye Hospital, Philadelphia, was named among the country's "Best Mental Health Experts" in the February 1994 issue of *Good Housekeeping*.

March 30 is

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The day was first celebrated on March 30, 1933, by the Auxiliary of Georgia's Barrow County Medical Society, commemorating the day in 1842 when Crawford W. Long, M. D., first used ether anesthesia in surgery.

The Georgia native graduated from medical school at the University of Pennsylvania, Philadelphia.

The red carnation is the symbol of Doctors' Day, celebrated nationally.

CASE REPORT

UNUSUAL PRESENTATION OF ROCKY MOUNTAIN SPOTTED FEVER

Maurice J. Lewis, MD, FACP

A 25-year-old, white female presented with a four-day history of marked left occipital, posterior cervical, and auricular tender lymphadenopathy, one week after sustaining a tick bite to the left parietal area, where a small papule was subsequently noted. Constitutional symptoms started on day five of the illness and progressed over the next 48 hours to high fever, diffuse myalgias, nausea, vomiting, chills, headache, photophobia, and a macular eruption which progressed from the trunk to the extremities, including the hands and feet. She became progressively obtunded, but, on admission, was not shocky. There was no other significant lymphadenopathy. She responded to intravenous Doxycycline over the next five days, Rocky Mountain spotted fever IgG and IgM antibodies rising from less than 1:64 to greater than 1:1024 and 1:320 respectively over a two-week period. Recovery was uneventful.

Rocky Mountain spotted fever is unusual in Pennsylvania, seven cases out of 289 nationwide having been reported in the past year, four of 628 in 1991.[1,2] Some of these cases reflected travel to more endemic areas, e.g., South Atlantic and South Central States. Our case gave no history of such travel.

What is even more unusual is the presentation of marked regional lymphadenopathy several days prior to onset of constitutional symptoms. Although mild generalized lymphadenopathy may be present in up to five percent of cases within the first three days of illness,[3,4] there is no evidence in the literature of marked regional lymphadenopathy as a presenting complaint, spread probably being more commonly hematogenous rather than lymphatic, as demonstrated by the presence of rickettsia in the endothelium of small vessels.[5] In addition, Rocky Mountain spotted fever usually starts with an abrupt onset of constitutional symptoms followed by an exanthem starting on the extremities, progressing centripetally to the trunk. In only 10 percent of cases does the eruption start centrally.

As previously emphasized, one must be continually aware of atypical features both in presentation and epidemiology.[6] Since its first description among residents of the Bitter Root and Snake River Valleys of Montana and Idaho in the past century, the diagnosis of Rocky Mountain spotted fever has been based solely on clinical judgment. Only here rests the cure of this potentially fatal disease.

For additional information, call Maurice J. Lewis, MD, FACP, at Freedman, Kaneson & Lewis Associates, (717) 761-3875.

References

1. *Morbidity and Mortality Weekly Report*, Vol. 41, No. 35, p. 651.

2. *Morbidity and Mortality Weekly Report*, Vol. 41, No. 34, p. 637.

3. **Weber DJ, Walker DH.** Rocky Mountain spotted fever. *Inf Dis Clinics of N Ame* 5:19-35, 1991.

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5. **Dumler, JS.** Fatal Rocky Mountain spotted fever in Maryland—1901. *JAMA* 265:718, 1991.

6. See note 4.

MEDICAL ABSTRACT

LIVER PACKING FOR UNCONTROLLED HEPATIC HEMORRHAGE AFTER TRAUMA

Michael A. Erdek, MD;
Sheldon Brotman, MD

OBJECTIVE: Liver packing is an option for the surgeon faced with hepatic hemorrhage as a function of traumatic injury. Originally popularized in the early 1900s, liver packing was condemned towards the middle of this century after World War II. However, it has been reevaluated in certain situations of hepatic trauma. This case report details the use of liver "sandwich" packing for uncontrolled hemorrhage.

METHODS: A 38-year-old male victim of a motorcycle accident was presented to the emergency department with a blood pressure of 90 mmHg/palpable and a hemoglobin of 6 gm/dl. An exploratory laparotomy revealed a large liver laceration and profound hemorrhage.

A "sandwich" technique of liver packing—where tamponade of the hemorrhage is achieved by placement of packs both above and below the liver bed, causing an effective compression of the liver—was employed to prevent patient mortality in the face of exsanguinating hemorrhage and multiple transfusions.

RESULTS: The patient made an uneventful postoperative recovery. Two weeks after his initial injury, he was stable enough for transfer out of the intensive care unit; a week later he was judged fit for transfer to a rehabilitation unit.

CONCLUSION: Massive liver hemorrhage after blunt trauma may be uncontrolled by conventional means. Failure to achieve hemostasis requires multiple transfusions and further worsens the coagulopathy already existent due to liver trauma. Liver packing is an appropriate and successful means of controlling this type of exsanguinating hemorrhage. Further, it may prevent impending mortality and allow ultimate survival of an otherwise lethal injury.

For additional information or a copy of the complete study, contact Michael A. Erdek, MD, at Geisinger Medical Center, (717) 271-6211.

The editors of PENNSYLVANIA MEDICINE encourage submission of scientific articles for publication consideration; however, abstracts of those articles not published in full are printed as a reference for readers. Please send submissions to: Medical Editor, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Full scientific articles are published at the discretion of the medical editor as consistent with the editorial schedule and are subject to revision.

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The Resolution Committee of the Pennsylvania Delegation to the AMA has set **March 31** as the deadline for receiving resolutions to be considered for submission to the AMA House of Delegates at the June 1994 Annual Meeting. Resolutions received after this date will be considered for the December 1994 Interim Meeting of the AMA House.

Send resolutions to:

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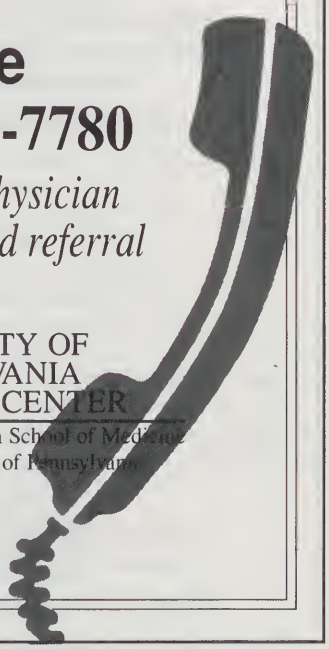

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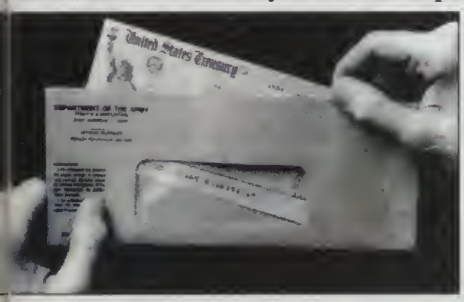

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Clinical Ethics Help Clarify Complex Times

Ralph A. Capone, MD

Reprinted with permission from the Westmoreland County Medical Society Bulletin, *June 1993.*

"Clinical ethics helps the physician find what is right and good for a patient at that particular point in a patient's life."

Dr. Capone, an internist and geriatric physician, is a member of the Board of Trustees, Jeannette District Memorial Hospital, Jeannette, and chairman of the Institutional Ethics Committee, Mercy Hospital, Pittsburgh.

Medical ethics has come a long way in the U.S. since the early 1960s. This discipline rapidly evolved after Dr. Belding Scribner invented the permanent arteriovenous access shunt which bears his name. His device provided a practical way to dialyse renal failure patients.

As there were many such patients, most of whom lacked the financial resources to afford this treatment, the so-called Seattle "God Committee" was formed. It consisted of a group of lay persons who chose who received hemodialysis. Widely criticized, this committee used social-worth criteria to determine who would benefit from this innovative and expensive technological breakthrough.

In 1972, this controversy finally ended when the federal government provided funding for hemodialysis for *all* end-stage renal disease patients. Although this may have ended the controversy, it did not address how to decide future dilemmas in which many patients feel entitled to various treatments which the government cannot fully subsidize.

The medical profession had recognized the limits of government intervention in health care and also had realized that medicine was becoming a more complex technological and moral enterprise. The era of rigorous medical ethics began.

Physicians realize that they practice in a pluralistic society. Patients, families, and health care professionals do not always share the same cultural heritage and values.

Physicians must have not only technical skills to practice good medicine, but also caring skills, listening skills, and empathy. But to serve patients in this way requires a commitment to technically competent, technically compassionate, and ethically sound medical care. Clinical ethics has evolved since the 1960s to help clinicians practice this kind of medicine.

But clinical ethics is *not* a separate discipline from clinical medicine. It has no other agenda nor function but to help the medical profession achieve its goals of curing disease and relieving suffering. It is *not apart from but a part of* clinical medicine.

William May, in *The Physician's Covenant*, calls clinical ethics "corrective vision" because it helps clinicians *see* the clinical situation in a different light. Clinical ethics helps the physician find what is *right* and *good* for a patient at that particular point in a patient's life.

The technical advances of medicine have created complicated choices for patients and physicians. The basic principles of medical ethics—autonomy, beneficence, and non-maleficence—are applied in clinical situations in order to help clarify the roles and values of patients, families, and health care professionals as each strives to make the best decisions. In an open society, these principles become "action-guides" for each participant as they go through the decision-making process. They also serve to protect patients from harm and abuse. Clinical medicine is indebted to these ethical principles because they have provided a framework for rational discourse on differing values and value conflicts in the medical decision-making process.

But ethical principles do not insure the recognition or relief of patients' suffering. Clinical ethics focusing on principles alone miss much of clinical reality. For any patient, that reality is being in the middle of his or her life's narrative and suddenly being cut off from all that is familiar by a particular illness.

What a patient wants, among other things, is restoration of his or her sense of "wholeness" or "well-being." It is from this loss of wholeness that patient suffering arises. But in order to relive suffering, first it must be recognized.

Clinical ethics, in going beyond principles and grounding itself in the "narrative unity" of a patient's life story, begins to approach an "ethics of care." Caring, for years done so well by the nursing profession, teaches physicians how to *see* suffering and starts them on the way toward reducing or alleviating it. To learn the art of medicine is really the task of clinical ethics, which is really about teaching physicians how to *care for* and *care about* patients.

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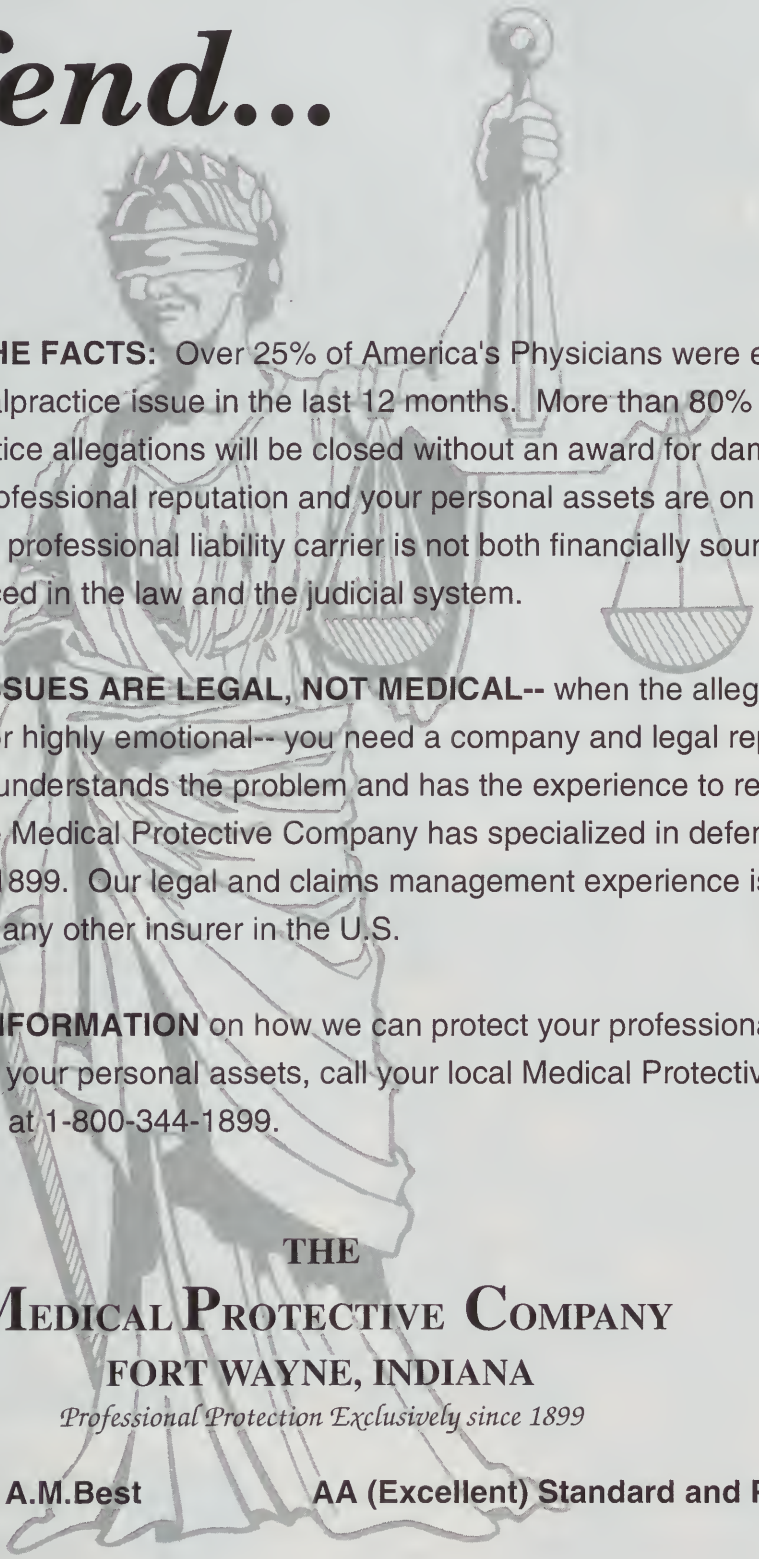

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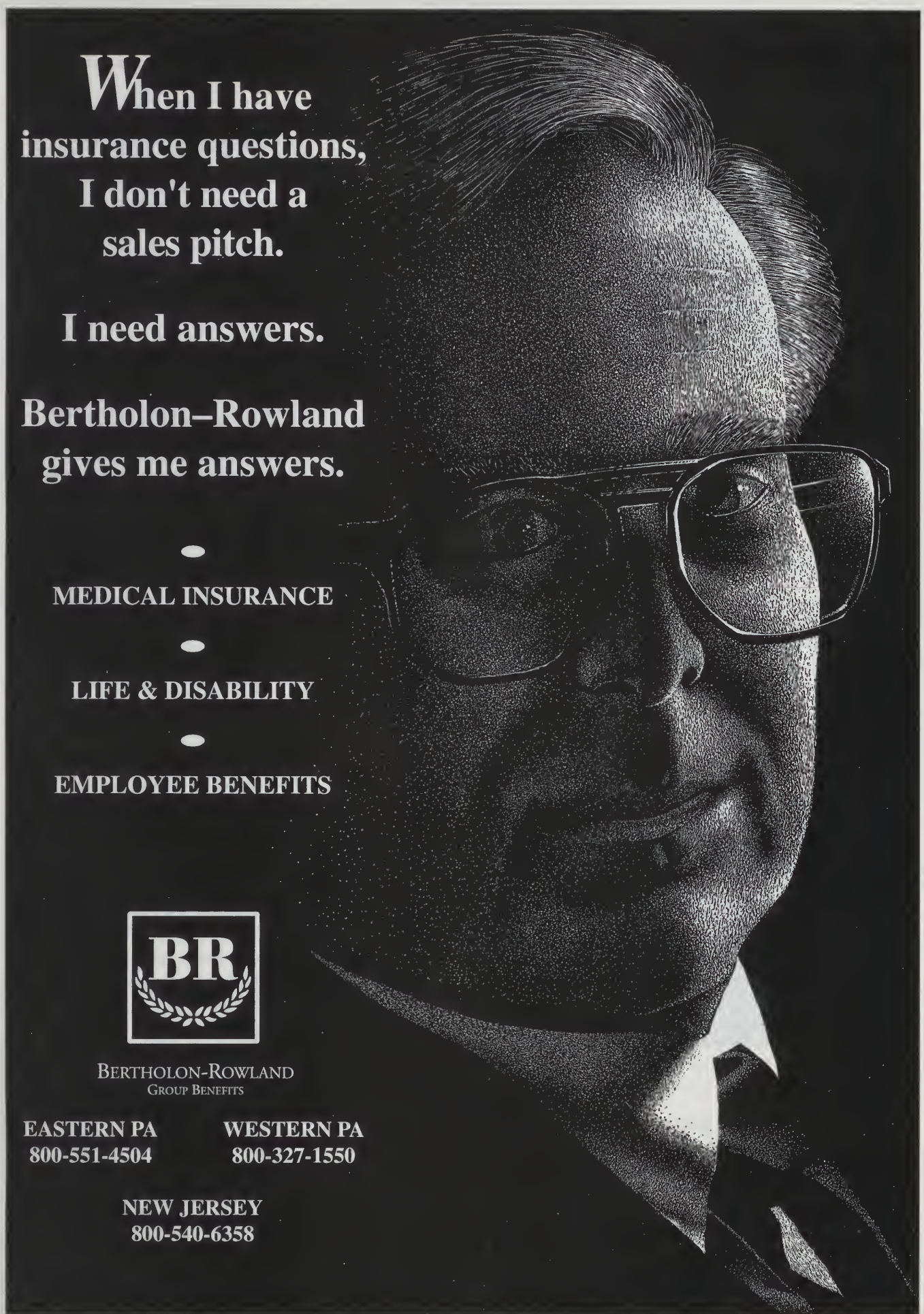
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SpectraComp, Mechanicsburg

12 New Therapeutic Agents Marketed in 1993

In this first in a series of articles reviewing the 22 therapeutic agents first marketed in 1993, a pharmaceutical expert considers seven agents and their most important properties, and compares them with similar agents also available.

Cover photo by Blair Seitz©, Harrisburg

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"Unfortunately,

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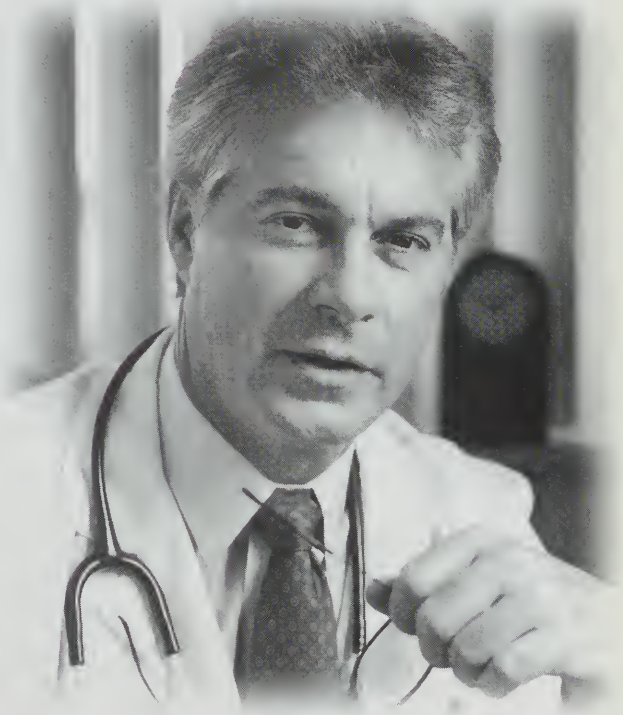

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FREE APPEAL REPRESENTATION OFFERED FOR MEMBERS: The State Society has been working with the AMA and other states involved in the Medicare clinical lab overpayment issue to minimize hassles in the appeals process. The carrier handling the appeals process, Blue Cross-Blue Shield of Maryland, has agreed to pursue joint representation of physicians for what is probably the most important and universal issue—the "at fault" issue. *Members who have not already received information and who are interested in this "consolidated" appeal process should contact the Society's Legal Department at (800) 228-7823* ***as soon as possible.***

The consolidated appeal will be handled by the AMA's outside counsel, Sidley and Austin. The AMA will pay a large portion of the costs, with the states sharing a portion as well. ***There will be no charge to the physicians involved.***

Inclusion in the consolidated appeal would apply to the "at fault" issue only, and physicians who wish to raise other issues may want to consult with personal counsel. While resolution of the "at fault" issue may completely resolve most cases, physicians who believe the amounts stated in the Blue Shield overpayment demand letter are incorrect, or who wish to raise other personal issues, may be foreclosed from raising those issues at a later date if they do not address them at the outset.

The Society has been instrumental in negotiating a resolution on behalf of physicians involved in the issue. Among other concessions, the Society has negotiated a decrease in the number of physicians required by the Health Care Financing Administration to make repayment (from 1,451 to 343), an increase in the length of installment payment options, and waivers of interest payments.

HCFA DENIES SOCIETY REQUEST FOR SINGLE MEDICARE CHARGE CLASS: The Society on April 6 received a letter from the Health Care Financing Administration (HCFA) denying our request that Pennsylvania be converted to a single statewide payment area under the Medicare physician fee schedule. According to HCFA Administrator Bruce C. Vladeck, "We do not believe that [the Society's] request meets our criterion of demonstrating overwhelming support among both winning and losing physicians for a statewide payment area. Rather, it appears that there is significant opposition to the change among losing physicians."

GOVERNOR EXPECTED TO APPROVE COVERAGE FOR PAP SMEARS: The state House of Representatives on March 22 passed Senate Bill 1103, requiring health insurers to provide coverage for pap smears. The vote was 193-3. Sponsored by Senator Allyson Schwartz (D-Philadelphia), the bill was previously approved by the Senate, and since there were no House amendments, it moved to the governor's desk. At press time, the governor was expected to sign the bill in mid-April.

NEWSPAPER ADVERTISEMENTS CARRY MEDICINE'S MESSAGE: Full-page advertisements, headlined "We agree," appeared in the *Washington Post, New York Times, Wall Street Journal,* and *USA Today* on March 8. Signed by the medical societies of all 50 states and the District of Columbia, and by 64 national specialty societies, the ads contain the text of a letter sent to the White House and Congress outlining basic reform principles—universal coverage, patient choice—backed by the signing organizations.

AMA LAUNCHES ANTI-TOBACCO CAMPAIGN: The AMA in March launched a new anti-tobacco campaign, including a program to help Americans quit smoking, federal laws to regulate tobacco products, and new efforts to ban smoking in public places. The AMA will apply pressure at local, state, and federal levels to protect non-smokers from the effects of passively inhaled cigarette smoke.

MEMBERS PREPARED FOR SPRING ASSEMBLY: At press time, more than 260 members were registered for the Society's annual Spring Assembly, to be held April 19-20, 1994, in Harrisburg. Featured are speeches on the future of medicine and health system reform, and tools for dealing with the future. For late registration, call the Society at (800) 228-7823.

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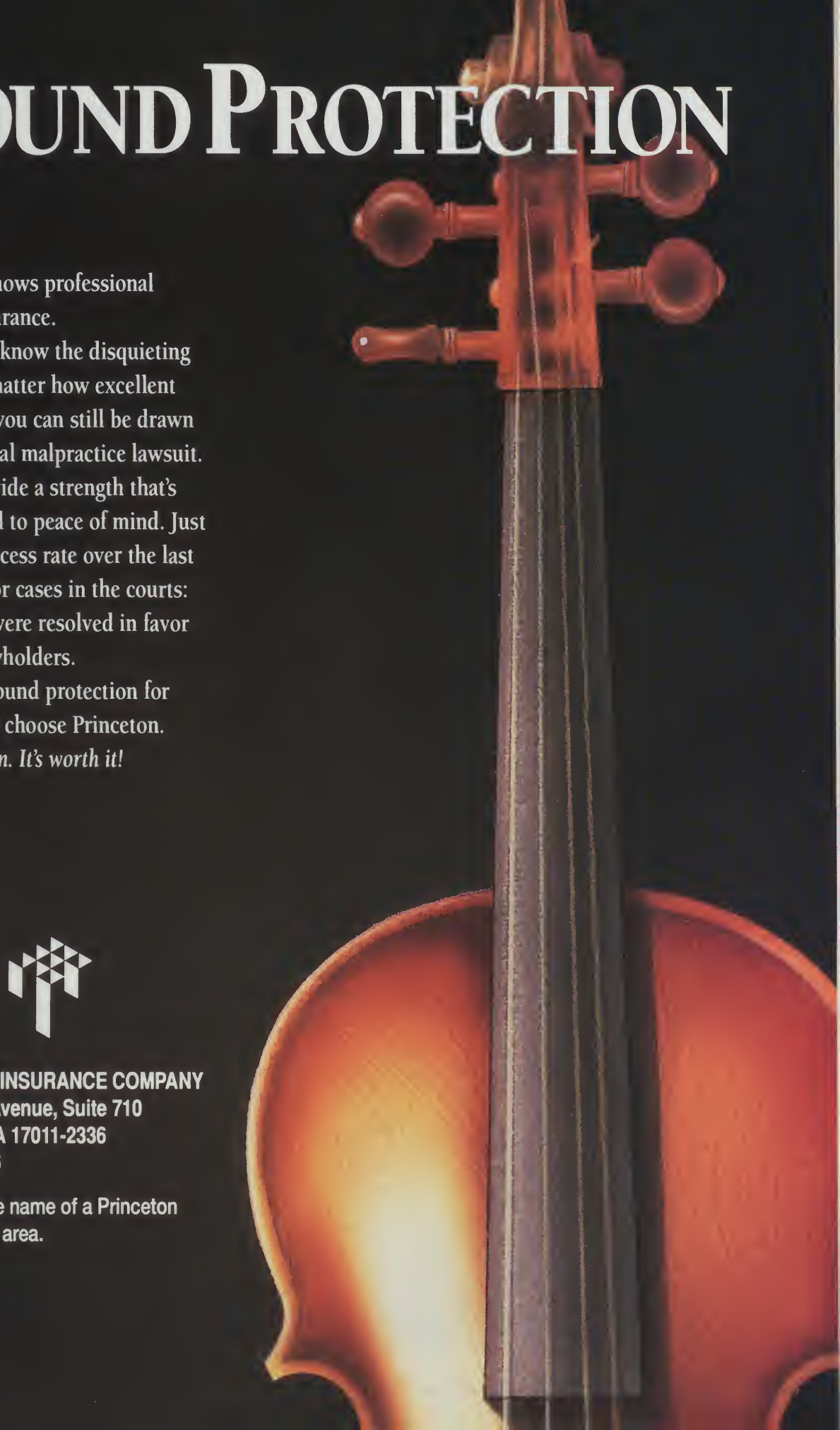

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The Big Push

John W. Mills, MD
Medical Editor

I was privileged to attend the AMA's March 8 rally in Washington, DC, entitled "Partnership In Action: Uniting For America's Health." The day was filled with congressional speakers, and because of a State Society board meeting on March 9, we had to squeeze in our congressional visits.

The AMA is trying very hard to get the message across that American physicians are united and really agree on three areas of concern: physician voice on health system reform, patient choice of physician, and universal coverage.

There was some fatherly advice from a speaker about endorsing broad issues which, when they change as time goes by, locks us in with no way to retreat without losing credibility. The American College of Surgeons just experienced this when they issued an "Explanatory Letter" on their endorsement of the single-payer system.

Eleanor Clift of *Newsweek* and Fred Barnes of the *New Republic* set the stage for the rally through their views on the Clinton Plan and their ideas about the congressional time table. Clift sees a window of opportunity for Clinton's plan if hearings progress rapidly. She also feels Whitewater could bring down the messenger (Hillary) and thus the message—Hillary's task force and their plan.

Surprisingly, Barnes generally agreed with Clift. He sees the problem as a two-government White House—Hillary wanting to hold the line on the task force's plan, and Bill willing to compromise. He also thinks the White House needs to move rapidly, or they'll lose it.

U.S Representative Newt Gingrich (R-GA) favors the Michel-Lott bill (H.R. 3080), which was entirely new to us all. He sees no consensus at all on the hill. He warns of a secret bill written by Representative Dan Rostenkowski (D-IL) which will be rushed to the floor in record time, having been dealt with in committee by the "Democratic enforcers." Rostenkowski has problems of his own which may defeat the above possibility. Meanwhile, Representative Jim McDermott (D-WA) touted his own bill.

Senator Phil Gramm (R-TX) made more sense than all the other speakers. He's an elder statesman, weathered by years in the Senate. He said the Clinton plan takes away some basic freedoms by mandates, and observed that under the Clinton plan all federal employees are exempt. Why, if it's good for all the rest of us? I believe Senator Gramm wants a bill passed this year, but he firmly believes that "we can't fix what's wrong by destroying what's right with our system." Along that line, Senator Bob Dole (R-KS) also feels a bill of some sort will pass; however, neither senator elaborated.

We spent some time with Congressman John Murtha (D-PA), who expressed more substance on what we might expect in a health system reform bill. Tort reform is a lost cause, and he seriously doubts we'll ever see anything until the *public* demands it. Preventive medical measures and antitrust relief are definite possibilities. He favors the incremental approach to health system reform and envisions yearly changes to fix most problem areas.

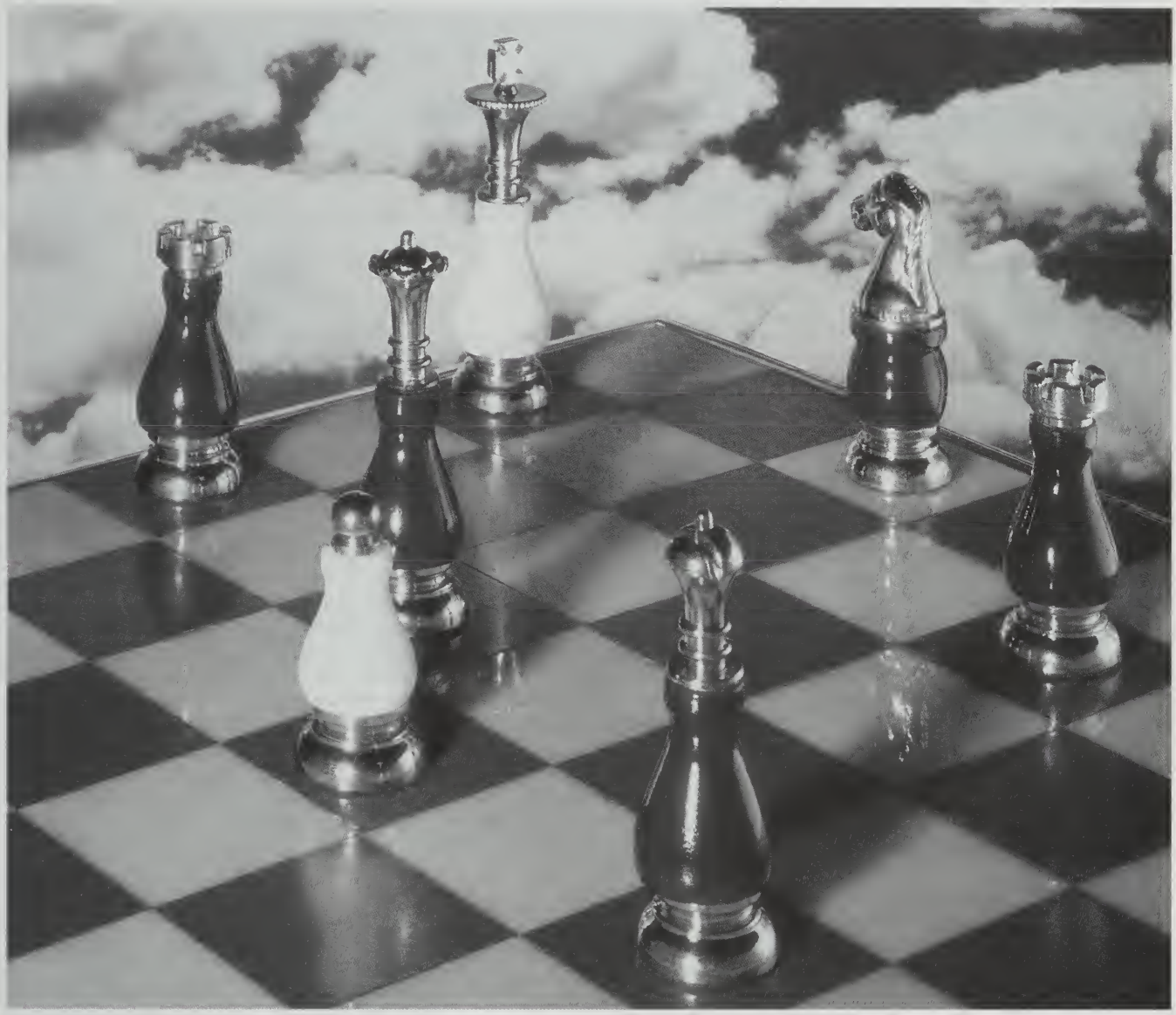
All speakers stressed our grassroots ability to talk with our patients about the issues and an important duty to our profession to keep in close contact with our legislators in both congressional houses.

Thus, the "big push" is on—talk to your patients and your congressional legislators. This may very well be our last chance.

A couple of quotes from the meeting are worth mentioning and should serve to put this all in a bit lighter perspective. Attributed to John McLaughlin of "The McLaughlin Group": "If you think health care is expensive, wait till it's free!" And from Congressman Gingrich: "If you like public housing, you'll love public medicine!"

I'll close with a thought-provoking quote from the February 14, 1994, *Wall Street Journal* by Swiss medical philosopher Ernest Truffer. "The increasing interjection of third parties between doctor and patient amounts to a rejection of the *medical ethic*—which is to care for a patient according to the latter's specific requirements—in favor of *veterinary ethic,* which consists in caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner." ⬡

The author (third row from bottom, right) contemplates health system reform amid legislators' speeches at "Partnership In Action: Uniting For America's Health," the AMA's March 8 rally in Washington, DC.



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Society Efforts Focus on Good of All

Martin A. Murcek, MD

As I travel around the state and meet with members of the Society, one of the most frequent questions I hear is, "What is the Society doing for me?" The only thing difficult about answering this question is trying to decide where to begin.

The Society undertakes such a range of activities and initiatives on behalf of the physicians of Pennsylvania that it's easy to leave something out of the answer. Let me describe a few of our efforts.

Possibly the most important service we are providing to our members is not readily visible: the constant activity of our lobbyists. If you ask your state legislator, and he or she replies honestly, you'll find that our lobbyists receive an A+ rating. They are prepared and knowledgeable.

Our staff monitors the *Pennsylvania Bulletin*, and keeps our lobbyists up-to-date on the status of bills moving through the state legislature. This effort allows us to be heard during the development of the specific regulations in new laws. As a result, many regulations are more physician-friendly by the time they go into effect.

A lesson learned during the fights over workers' compensation and auto insurance, as they related to physicians' fees, we have developed "Quick Response Committees," made up of Society leaders and physicians knowledgeable in the specific issue being addressed. This way, we are more responsive and flexible when the time comes to oppose or re-direct legislative initiatives that are potentially damaging to the medical community.

One thing that frustrates me a great deal is that I don't feel our members read their mail, at least that which comes from the Society. I know we are all inundated with mail, but the Society makes some valuable resources and information available to the membership through its mailings.

About four years ago, the Forbes Group of Virginia worked with the Society to restructure our communication activities. We have cut down on the size, volume, and complexity of our publications and other mailings. Check out *Executive Report,* and for those of you who receive it, *Call to Action.* The latter may be one of our most important mailings, because it alerts *you* to what your local legislators are up to with respect to legislation that affects physicians. Your direct communications with your local legislators are crucial to getting our message heard. *Call to Action* lets you know who in Harrisburg needs to hear directly from you on the issues.

It's important to remember that politicians perceive physicians as another special interest group, not as individuals or as individual specialties. The Society's approach to representing all of us is more effective than the scattershot efforts of a bunch of specialty groups all shouting over each other to be heard.

> ***"...the Society makes some valuable resources and information available to the membership through its mailings."***

Recently, the Society formed a management service organization (MSO, see page 20) which is designed to advise physicians on a variety of issues related to the business side of our profession. The new company will provide information on managed care, and offer assistance to physician groups forming their own locally controlled and operated health maintenance organizations and independent practice associations.

So, while the Society may not seem to be devoting as much of its efforts to *your* particular specialty or region of the state, remember that we are working for *all* our members as hard as the leadership and staff possibly can!

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LETTERS TO THE EDITOR

CURRENT CONCEPTS II PRAISED BY MANY

The Pennsylvania Academy of Ophthalmology received several letters praising its "Current Concepts in Ophthalmology," mailed with the February issue of PENNSYLVANIA MEDICINE. *The following is a sampling of comments:*

"Although I have retired from the practice of internal medicine in Philadelphia, I'm still interested. I found the publication of 'Current Concepts in Ophthalmology' in 1993 and 1994 excellent and most interesting. I hope the Pennsylvania Academy of Ophthalmology will continue the series."

E. Cooper Bell, MD
Lancaster, SC

"I liked the ophthalmology supplement to PENNSYLVANIA MEDICINE. It was well written, concise, and well illustrated. It would be nice to have similar supplements from other specialties."

Michael C. Beachley, MD
Pittsburgh

The journal was "excellent, [an] outstanding example of ophthalmic outreach programs. Hopefully you will continue to provide a forum for education and debate."

Submitted anonymously

Next Month in PENNSYLVANIA MEDICINE

Daniel A. Hussar, PhD, the Remington Professor of Pharmacy at the Philadelphia College of Pharmacy and Science, continues his overview of the 22 therapeutic drugs first marketed in 1993, including their most important properties and comparisons with similar drugs.

For the first article in Dr. Hussar's series, see pages 12-16 of this issue.

Your Letters Are Welcomed

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Letters should be typed or legibly handwritten, concise, and should not exceed 200 words.

Please send letters to:
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3:30-4:00	Coronary Artery Regression: Fact or Fiction	*Steven A. Sibler, M.D.*
4:00-5:00	Case Presentation	*Christopher Mallavarapu, M.D.*
	Panel Discussion *Jack L. Garden, M.D.*	*Bradford J. Lin, M.D.*
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New Therapeutic Agents Marketed in 1993

Daniel A. Hussar, PhD

This is the first in a series of articles overviewing new drugs approved and marketed in the U.S. in 1993.

In 1993, the Food and Drug Administration (FDA) approved 25 new molecular entities (NMEs), 23 of which are for therapeutic use and two are diagnostic agents. Eleven of the NMEs for therapeutic use, as well a new biological agent intended for therapeutic use, were both approved and marketed in the United States in 1993. In addition, 11 other NMEs that the FDA approved before 1993 (most in late 1992) were marketed during the year. Thus, a total of 23 therapeutic agents reached the U.S. market for the first time in 1993, a considerably lower number than the 30 new therapeutic agents marketed in 1992 and the record number 31 new agents marketed in 1991. Many of the 13 therapeutic agents approved in 1993 but not marketed before the end of the year have become available in early 1994.

This review of the therapeutic agents first marketed in 1993 considers their most important properties and, when possible, compares them with other available agents with similar properties. Of the 23 new therapeutic agents, 22 are considered in this paper. The one agent not reviewed is flosequinan, which was withdrawn from the market after being available only several months because of a concern about toxicity. This discussion of new drugs focuses on the most important properties of these agents; when additional information is needed, more comprehensive references and the product literature should be consulted.

Antibiotic

Piperacillin sodium/tazobactam sodium (Zosyn-Lederle) represents a combination of a new beta-lactamase inhibitor (tazobactam) with a penicillin antibiotic that has been marketed for a number of years. Of the 14 penicillin derivatives marketed in the U.S. (see Table 1, next page), piperacillin is the fourth to also be marketed in combination with a beta-lactamase inhibitor, joining amoxicillin, ampicillin, and ticarcillin. The most common form of bacterial resistance to the beta-lactam antibiotics involves the production of beta-lactamase enzymes. By inactivating these enzymes, the beta-lactamase inhibitors protect antibiotics such as the penicillins from destruction by the enzymes, resulting in the enhancement of the spectrum of action of the penicillins to include bacteria that are normally resistant.

Tazobactam is the third beta-lactamase inhibitor to be used in the U.S., joining potassium clavulanate and sulbactam. The new agent demonstrates inhibitory activity against most of the classes of beta-lactamase enzymes that have been identified, and appears to be more active against a wider spectrum of enzymes than its two predecessors. Tazobactam is a derivative of the penicillin nucleus but has minimal intrinsic antibacterial activity. When used in combination with piperacillin, the synergistic action is due to the inhibition of beta-lactamases by tazobactam, and the resultant extension of the spectrum of activity of piperacillin to include certain bacteria that are not susceptible to piperacillin when given alone.

Piperacillin/tazobactam is as active as the first-generation cephalosporins (e.g., cefazolin [Ancef]) against gram-positive aerobic bacteria and the third-generation cephalosporins (e.g., ceftriaxone [Rocephin]) against gram-negative aerobic bacteria. Its coverage against enterococci is comparable to ampicillin, and its coverage against anaerobic bacteria is similar to metronidazole (Flagyl). Because of its broad spectrum of activity, it may be useful as empiric monotherapy in patients with suspected polymicrobial infections. In comparative clinical trials in patients with polymicrobial infections, piperacillin/tazobactam had equal or greater efficacy than clindamycin (Cleocin) plus gentamicin (Garamycin), imipenem/cilastatin (Primaxin), and ticarcillin/potassium clavulanate (Timentin).

The labeled indications for piperacillin/ tazobactam include the intra-abdominal, gynecologic, skin, and lower respiratory tract infections noted in Table 2 (see next page). These indications are most similar to the labeled indications for ampicillin/sulbactam (Unasyn). In comparing the role of piperacillin/tazobactam with that for piperacillin, the new product would primarily be used as monotherapy for patients with suspected or documented polymicrobial infections, whereas piperacillin (without tazobactam) is most often used in combination with an aminoglycoside for infections in neutropenic patients or in patients with nosocomial pneumonia.

The use of piperacillin/tazobactam is contraindicated in patients with a history of an allergic reaction to any of the penicillins, cephalosporins, or beta-lactamase inhibitors. As with other penicillin formulations, an aminoglycoside (e.g., gentamicin) should not be combined with piperacillin/tazobactam in the same solution for administration because the aminoglycoside may be inactivated.

Piperacillin/tazobactam is administered by intravenous infusion over a period of 30 minutes. It is supplied in vials containing 2.25, 3.375, and 4.5 grams of the drugs, representing piperacillin sodium equivalent to 2, 3, or 4 grams of piperacillin and tazobactam sodium equivalent to 0.25, 0.375, or 0.5 gram of tazobactam, respectively. The usual adult dosage is 3.375 grams every six hours, and the usual duration of treatment is seven to 10 days.

Antimycobacterial agent

Rifabutin (Mycobutin-Adria; SmithKline Beecham; formerly known as ansamycin) is an antimycobacterial agent that is similar in many of its properties to rifampin (Rifadin, Rimactane). It is active against *Mycobacterium avium* and *Mycobacterium intracellulare*, which comprise *Mycobacterium avium* complex (MAC).

MAC disease is a potentially life-threatening opportunistic infection that often occurs in people with acquired immunodeficiency syndrome (AIDS). In the U.S., up to 40 percent of patients with advanced human immunodeficiency virus (HIV) infection develop MAC disease. Disseminated MAC infections are very difficult to treat and require the combined use of several antiinfective agents. Therefore, in addition to efforts to develop more effective treatments for infections, there have been studies of prophylaxis measures that can reduce the incidence and severity of MAC disease.

Rifabutin is indicated for the prevention of disseminated *Mycobacterium avium* complex (MAC) disease in patients with advanced HIV infection and is the first drug to be approved for such preventive therapy. In two clinical trials involving 1,146 patients with AIDS and CD4 counts $\leq$ 200 cells/μl, patients receiving rifabutin were two to three times less likely to develop MAC bacteremia than patients receiving placebo. On December 23, 1993, the FDA approved the use of clarithromycin (Biaxin) for the treatment of disseminated MAC disease, making it the first drug to receive an indication for the treatment

of this infection. It is recommended that clarithromycin be used in combination with other agents that have demonstrated activity against MAC, including ethambutol (Myambutol), clofazimine (Lamprene), and rifampin.

Rifabutin exhibits in vitro activity against many strains of *Mycobacterium tuberculosis*. However, rifabutin prophylaxis should not be administered to patients with active tuberculosis because of the possibility of the development of tuberculosis that is resistant both to rifabutin and rifampin. Cross resistance between the two agents is commonly observed with *M. tuberculosis* as well as *M. avium* complex isolates. Patients who develop complaints consistent with active tuberculosis while receiving rifabutin prophylaxis should be evaluated immediately, so that those with active disease may be given an appropriate combination regimen of antitubercular agents.

Like rifampin, rifabutin may cause a brown-orange discoloration of urine, feces, saliva, sputum perspiration, tears, and skin, as well as permanent staining of soft contact lenses. Patients must be advised of this possibility. Rifampin is also known to be a potent inducer of hepatic enzymes resulting in a faster rate of metabolism and a reduced therapeutic effect of concurrently administered drugs that are metabolized by these enzyme systems (e.g., warfarin [Coumadin], corticosteroids, oral contraceptives, cyclosporine [Sandimmune], and numerous other agents). Although rifabutin appears to be a less potent enzyme inducer than rifampin, the concurrent use of the new drug with other agents that are metabolized by hepatic enzyme systems should be closely monitored. Patients using oral contraceptives should be advised to use nonhormonal or additional methods of birth control while taking rifabutin.

The recommended adult dosage of rifabutin is 300 mg administered once daily. For patients who experience GI intolerance, administering 150 mg doses twice a day with food may avoid these effects. In the limited experience with its use in children, different doses were employed, with no evidence that doses greater than 5 mg/kg daily are useful. Doses of the drug for use in children may be administered mixed with foods such as applesauce.

Rifabutin capsules are supplied in a 150-mg potency.

Table 1

Penicillins and Penicillin/ Beta-Lactamase Inhibitor Combinations

Natural penicillins

Penicillin G potassium (e.g., Pentids)
Penicillin V potassium (e.g., Pen Vee K)

Penicillinase-resistant (antistaphylococcal) pencillins

Cloxacillin sodium (e.g., Tegopen)
Dicloxacillin sodium (e.g., Dynapen)
Methicillin sodium (e.g., Staphcillin)
Nafcillin sodium (e.g., Unipen)
Oxacillin sodium (e.g., Prostaphlin)

Aminopenicillins

Amoxicillin (e.g., Amoxil)
Amoxicillin/potassium clavulanate (Augmentin)
Ampicillin (e.g., Omnipen)
Ampicillin sodium/sulbactam sodium (Unasyn)
Bacampicillin (Spectrobid)

Extended-spectrum (antipseudomonal) penicillins

Carbenicillin indanyl sodium (Geocillin)
Mezlocillin sodium (Mezlin)
Piperacillin sodium (Pipracil)
Piperacillin sodium/tazobactam sodium (Zosyn)
Ticarcillin disodium (Ticar)
Ticarcillin disodium/potassium clavulanate (Timentin)

Table 2

Labeled Indications for Piperacillin/Tazobactam

- Appendicitis (complicated by rupture or abscess) and peritonitis caused by piperacillin-resistant beta-lactamase producing strains of *Escherichia coli* or the following members of the *Bacteroides fragilis* group: *B. fragilis. B. ovatus, B. thetaiotaomicron,* or *B. vulgatus.*
- Postpartum endometritis or pelvic inflammatory disease caused by piperacillin-resistant beta-lactamase producing strains of *Escherichia coli.*
- Uncomplicated and complicated skin and skin structure infections, including cellulitis, cutaneous abscesses, and ischemic/diabetic foot infections caused by piperacillin-resistant, beta-lactamase producing strains of *Staphylococcus aureus.*
- Community-acquired pneumonia (moderate severity only) caused by piperacillin-resistant beta-lactamase producing strains of *Haemophilus influenzae.*

Antifungal agent

Terbinafine hydrochloride (Lamisil-Sandoz) is the second allylamine derivative to be marketed for the topical treatment of dermatologic fungal infections, joining naftifine (Naftin). The new drug is indicated for the topical treatment of interdigital tinea pedis (athlete's foot), tinea cruris (jock itch), and tinea corporis (ringworm) caused by *Epidermophyton floccosum, Trichophyton mentagrophytes.* or *Trichophyton rubrum.* The oral administration of terbinafine is also being evaluated in the management of certain fungal infections; however, an oral formulation of the drug is not yet available.

With the use of many of the topically applied antifungal agents, it is recommended that the treatment of tinea pedis be continued for four weeks to provide control of the infection and to reduce the possibility of recurrence. In several of the studies of terbinafine in the treatment of tinea pedis, a high cure rate was attained with just one week of treatment. Studies comparing terbinafine with other antifungal agents are too limited at this time to reach a conclusion that the new drug has a significant advantage over previously marketed agents. However, the high level of activity of terbinafine against these fungal organisms, combined with a rapid onset of its fungicidal action, suggest the possibility of a shorter course of therapy (i.e., one week) which may help avoid treatment failures caused by noncompliance with longer treatment regimens (e.g., four weeks).

Terbinafine cream should be applied to the affected and immediately surrounding areas twice a day in the treatment of interdigital tinea pedis, and once or twice a day in the treatment of tinea cruris and tinea corporis. Treatment should be continued until clinical signs and symptoms are significantly improved; in many patients this occurs by the seventh day of drug therapy. The duration of drug therapy should be for a minimum of one week and should not exceed four weeks. Many patients treated with shorter courses of therapy (one to two weeks) continue to improve during the two to four weeks after drug therapy has been completed. Therefore, patients should not be considered therapeutic failures until they have been observed for a period of two to four weeks off therapy.

Terbinafine hydrochloride cream is supplied in a one percent potency.

Antiviral agent

Rimantadine hydrochloride (Flumadine-Forest) is an analog of amantadine (Symmetrel) that is active against in-

fluenza A virus. It is specifically indicated for the prophylaxis and treatment of illness caused by various strains of influenza A virus in adults, and for prophylaxis against influenza A virus in children. Although there has been considerably less experience with rimantadine than with amantadine, the results of the comparative studies that have been completed suggest that the two agents are similar in their efficacy against influenza A virus.

To prevent influenza infection, most recommend vaccination on an annual basis as the method of choice unless vaccination is contraindicated, not available, or not feasible. Early vaccination is advised to allow adequate time for the development of the antibody response prior to an influenza outbreak. If the vaccination is administered during an influenza outbreak, rimantadine or amantadine prophylaxis can be started when the vaccine is given and continued for at least two weeks until the protective antibody response develops from the vaccination.

Because rimantadine and amantadine may be effective in the treatment of influenza A virus infections, they should be considered for use in patients who develop an influenza-like illness during known or suspected influenza A infection in the community. However, treatment should be initiated as soon as possible after the onset of signs and symptoms of infection (i.e., within 48 hours) if a significant reduction of symptoms is to be attained.

In addition to its use for influenza A virus infections, amantadine is also indicated for the treatment of Parkinson's disease and drug-induced extrapyramidal reactions. However, these conditions are not indications for the use of rimantadine.

Rimantadine was well tolerated by most patients in controlled clinical trials. The new drug appears to be better tolerated than amantadine; in one prophylaxis study of 436 adults, seven percent of the subjects receiving rimantadine experienced adverse reactions (e.g., insomnia, dizziness, nausea, vomiting, anorexia) compared to 15 percent of those receiving amantadine, and four percent of those receiving placebo. Both rimantadine and amantadine have been reported to cause seizures in patients with epilepsy, and the use of these agents should be monitored closely in patients with a history of such a disorder.

The recommended dosage of rimantadine for prophylaxis or treatment in adults is 100 mg twice a day. A dosage reduction to 100 mg daily is recommended in patients with severe hepatic dysfunction or renal failure (creatinine clearance of 10 ml/min or less) and in elderly nursing home patients. When rimantadine is used for the treatment of influenza A virus infections in adults, therapy should be continued for approximately seven days from the initial onset of symptoms.

Rimantadine hydrochloride is supplied as tablets in a 100-mg potency and in a syrup formulation containing 50 mg/5 ml. Because of the similarity of the generic names rimantadine and ranitidine (Zantac), particular caution should be exercised in writing and interpreting prescriptions for these agents.

Antihypertensive agent

Bisoprolol fumarate is a beta-adrenergic blocking agent that has been marketed as a single agent (Zebeta-Lederle) and in combination with hydrochlorothiazide (Ziac). Both formulations are indicated for the management of hypertension, and Ziac is being promoted as "the first low-dose multimechanism agent approved and marketed as first-line therapy for the treatment of hypertension." The bisoprolol/hydrochlorothiazide combination contains low doses of both the beta-blocker and diuretic, and has been effective and well tolerated in the clinical studies. The formulation contains only 6.25 mg of hydrochlorothiazide in comparison to the 25 or 50 mg amounts (or the equivalent amount of another diuretic) included in other beta-blocker/diuretic combination products, and the new product would be less likely to cause dose-related adverse effects (e.g., hypokalemia).

Like acebutolol (Sectral), atenolol (Tenormin), betaxolol (Kerlone), and metoprolol (Lopressor), bisoprolol is cardioselective (i.e., selectively acts at $beta_1$-adrenergic receptors). This cardioselectivity is not absolute, however, and in higher doses (20 mg and above), bisoprolol also inhibits $beta_2$-adrenergic receptors located in the bronchial and vascular musculature. In general, patients with bronchospastic pulmonary disease (e.g., chronic bronchitis, emphysema) should not receive a beta-adrenergic blocking drug because of the risk of exacerbation of the pulmonary disorder. However, in the event that a patient with bronchospastic disease does not respond to or cannot tolerate other antihypertensive treatment, bisoprolol or another beta-blocker with relative cardioselectivity may be used cautiously in the lowest possible dose. A $beta_2$-agonist (bronchodilator) should be available in these situations.

In patients with coronary artery disease, the abrupt cessation of bisoprolol therapy may cause an exacerbation of angina pectoris and, in some instances, myocardial infarction or arrhythmia. Patients should be warned against interrupting or discontinuing their therapy without consulting their physician and, when bisoprolol therapy is to be discontinued, it is best to gradually reduce the dosage over a period of one week.

Bisoprolol may potentiate the action of other antihypertensive agents and should not be used concurrently with another beta-blocker. In patients receiving concurrent therapy with clonidine (Catapres), if therapy is to be discontinued, it is recommended that bisoprolol be discontinued for several days before the withdrawal of clonidine. Caution should also be exercised when using bisoprolol concurrently with myocardial depressants or inhibitors of AV conduction, such as certain calcium channel blockers (particularly, verapamil [Calan, Isoptin] and diltiazem [Cardizem]) or antiarrhythmic agents such as disopyramide (Norpace).

The usual starting dosage of bisoprolol is 5 mg once a day. If the antihypertensive effect is inadequate, the dose may be increased to 10 mg and then, if necessary, to 20 mg once daily. Bisoprolol fumarate tablets are supplied in 5- and 10-mg potencies. The combination formulations with hydrochlorothiazide contain 2.5, 5, or 10 mg of bisoprolol fumarate with 6.25 mg of the diuretic.

Antiarrhythmic agent

Sotalol hydrochloride (Betapace-Berlex) is a new antiarrhythmic agent that is unique because it both prolongs cardiac repolarization (Vaughan Williams Class III) and has beta-adrenergic-blocking activity (Vaughan Williams Class II). The beta-blocking action of the drug is non-cardioselective and is not associated with intrinsic sympathomimetic or local anesthetic activity.

Sotalol is indicated for the treatment of documented life-threatening ventricular arrhythmias such as sustained ventricular tachycardia. Because of the potential for causing proarrhythmic effects, its use in patients with less severe arrhythmias, even if the patients are symptomatic, is generally not recommended. In the clinical studies, sotalol was determined to be at least as effective as the other antiarrhythmic agents to which it was compared (e.g., quinidine, procainamide [Pronestyl], mexiletine [Mexitil], and propafenone [Rythmol]). Sotalol has not been demonstrated to have a beneficial effect on survival, but neither has it been shown to produce increased mortality, as has been the experience with certain other antiarrhythmic agents (e.g., encainide [Enkaid—withdrawn from the market]). In several studies, sotalol has been reported to be effective in suppressing supraventricular tachycardias

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Clinical Associate Professor of Medicine
Georgetown University School of Medicine
Medical Director, Diabetic Treatment Center
Washington Hospital Center
Washington, DC

Implications for the Elderly Diabetic
Jesse Roth, MD
Lublin Professor of Medicine
Director, Division of Geriatric Medicine and Gerontology
Johns Hopkins School of Medicine
Baltimore, Maryland

April 13th
The Pathophysiology and Management of Syncope
Bernard J. Gersh, MB, ChB, DPhil, FRCP
W. Proctor Harvey Teaching Professor of Cardiology
Chief, Division of Cardiology
Georgetown University School of Medicine
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Rheumatoid Arthritis: Common vs. Rare Manifestations
Steven Berney, MD
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Section of Rheumatology
Temple University School of Medicine
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Glomerular Diseases: Present Concepts and Future Directions
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MAY 1994

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Francis M. Giardiello, MD
Associate Professor of Medicine
Division of Gastroenterology
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May 11th
Similarities Between Atherosclerotic Plaque Growth, Restenosis and Neomicrocirculation
Valentin Fuster, MD, PhD
Arthur M. & Hilda A. Master Professor of Medicine
Director, Cardiovascular Institute
Vice Chairman, Department of Medicine
Mt. Sinai Medical Center
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May 18th
Analgesic Nephropathy
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Mt. Sinai School of Medicine
Chief, Division of Nephrology and Hypertension
Beth Israel Medical Center
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and atrial fibrillation. However, these are not labeled indications for the drug at this time.

Like other antiarrhythmic agents, sotalol may cause proarrhythmic events, and the occurrence of torsades de pointes (four percent) and other serious new ventricular arrhythmias (one percent) are the most important adverse effects associated with the use of the new agent. These reactions are most likely to occur within seven days of initiating therapy or of an increase in dose. A reduction in serum potassium and/or magnesium also increases the risk of torsades de pointes, and sotalol should not be used in patients with hypokalemia or hypomagnesemia prior to the correction of the imbalance.

A number of therapeutic agents, such as the Class I antiarrhythmic agents (e.g., quinidine, procainamidc. disopyramide [Norpace]), tricyclic antidepressants, phenothiazines, terfenadine (Seldane), and astemizole (Hismanal), are known to prolong the QT interval. The concurrent use of sotalol and one of these agents is best avoided; however, in some situations concomitant therapy may be necessary.

Sotalol has been used safely in the long-term treatment of life-threatening ventricular arrhythmias following a myocardial infarction (MI). However, its use in the early phase of recovery from acute MI is limited, and in two studies in post-infarction patients, involving the use of a nontitrated initial dose of 320 mg once daily and 320 mg twice daily, respectively, there were suggestions of an excess of early sudden deaths. Particular caution in the first two weeks post-MI is recommended, and careful dose titration is important, especially in patients with markedly impaired ventricular function. Many of the other precautions to be observed with the use of sotalol are related to its beta-blocking activity.

In addition to the possible drug interactions described earlier, there are several other interactions in which sotalol may be implicated. Additive effects would be expected if sotalol was used concomitantly with other Class III antiarrhythmic agents (e.g., amiodarone [Cordarone]) or beta-adrenergic blocking agents (e.g., propranolol [Inderal]). Concurrent use with a calcium channel blocking agent (e.g., verapamil [Calan, Isoptin]) may result in additive effects on atrioventricular conduction or ventricular function, as well as on blood pressure, possibly leading to hypotension. When sotalol is administered concurrently with a beta$_2$-receptor agonist (e.g., terbutaline [Brethine, Bricanyl]), the dosage of the latter agent may have to be increased.

It is best to begin therapy with sotalol in a hospital where the therapy can be very closely monitored. The recommended initial dosage of sotalol is 80 mg twice daily. The dosage may be increased, if necessary, to 240 or 320 mg/day, allowing two to three days between dosing increments in order to attain steady-state plasma concentrations and to allow monitoring of QT intervals. In most patients, a therapeutic response is obtained at a total daily dose of 160 to 320 mg/day, given in two divided doses. Some patients with life-threatening refractory ventricular arrhythmias may require doses as high as 640 mg/day. If sotalol is to replace previous antiarrhythmic therapy, the previous agent(s) should generally be withdrawn under careful monitoring for a minimum of two to three plasma half-lives.

Sotalol hydrochloride tablets are supplied in 80-, 160-, and 240-mg potencies.

Antithrombotic agent

About 250,000 patients undergo hip replacement surgery each year. There is a high risk of venous thromboembolism following this procedure and, in the absence of prophylaxis, the incidence of deep vein thrombosis (DVT) has been reported to range from 45 to 70 percent. DVT may lead to pulmonary embolism that may be fatal and, to prevent such complications, agents such as heparin or warfarin are usually employed for prophylaxis in patients undergoing hip replacement surgery.

Although the use of heparin for DVT prophylaxis has been effective and well tolerated in most patients, concern about the risk of bleeding reactions has lead to the development and evaluation of derivatives of heparin that may be less likely to cause this problem. The first such derivative to be marketed in the U.S. is *enoxaparin* (Lovenox-Rhone-Poulenc Rorer), a low molecular weight fraction of heparin that exhibits antithrombotic activity. Prepared by the degradation of heparin benzyl ester derived from porcine intestinal mucosa, enoxaparin has a higher bioavailability (following subcutaneous injection) and a longer half-life than unfractionated heparin.

In comparison to unfractionated heparin, enoxaparin has a higher ratio of anti-factor Xa to anti-factor IIa activity. The new agent does not significantly influence platelet aggregation or the plasma fibrinogen concentration, nor does it affect global blood-clotting tests (i.e., prothrombin time [PT] or activated partial thromboplastin time [APTT]).

Enoxaparin is indicated for the prevention of deep vein thrombosis following hip replacement surgery and represents an important addition to the small group of agents used for prophylaxis against this complication. It has been reported to be as effective or more effective than unfractionated heparin and, in some studies, the rate of major bleeding complications was comparable to that observed with placebo.

The use of enoxaparin has also been evaluated in the prevention of DVT following other surgical procedures (e.g., knee surgery, general surgery), and in the treatment of DVT. However, these are not labeled indications at the present time.

Although the incidence of hemorrhagic complications during enoxaparin treatment has been low, this is the reaction that warrants the greatest caution with the use of the new agent. The rates of major bleeding episodes during the clinical trials with enoxaparin, heparin, and placebo were four percent, six percent, and four percent, respectively. Enoxaparin is contraindicated in patients with active major bleeding and must be used with care in patients receiving oral anticoagulants and/or platelet inhibitors.

Enoxaparin is administered by subcutaneous injection and must not be administered by intramuscular injection. Its bioavailability is about 90 percent, and its maximum effect usually occurs three to five hours after injection. The recommended dosage is 30 mg twice daily subcutaneously, with the initial dose given as soon as possible after surgery, but not more than 24 hours post-operatively. This dosage regimen is recommended for all patients, and dosage titration is not necessary. Because the drug is not likely to affect PT or APTT, daily monitoring is usually not necessary in patients with normal presurgical coagulation parameters. Treatment should be continued throughout the period of postoperative care until the risk of DVT has diminished. The average duration of administration is seven to 10 days.

To administer enoxaparin, the patient should be lying down, and the drug is given by deep subcutaneous injection. Administration should be alternated between the left and right anterolateral, and left and right posterolateral abdominal wall. The whole length of the needle should be introduced into a skin fold held between the thumb and forefinger; the skin fold should be held throughout the injection.

Enoxaparin is supplied in prefilled syringes that contain 30 mg of the drug in 0.3 ml of Water for Injection.

Dr. Hussar is the Remington professor of pharmacy at the Philadelphia College of Pharmacy and Science.

SOCIETY OFFERS SECOND DRUG COST CHART

The Society's Center for Professional Drug Education and Information is continuing its efforts to provide physicians with the information they have requested on medication costs. This second in a series of charts focuses on *quinolone antibiotics*.

The new generation of quinolones offers an advantage over existing antibiotics because of their ability to eradicate multi-resistant pathogens. Generally, quinolones are *not* used as first-line therapy in infections encountered in the outpatient setting, such as otitis media, sinusitis, pharyngitis, and pneumonia. It has been determined that using quinolones inappropriately, in cases such as these, will increase the treatment expense, increase the failure rate, and increase the rate of bacterial resistance.

A quinolone antibiotic may be the drug of choice in the following conditions:

- bacterial conjunctivitis,
- infectious diarrhea,
- Salmonella carriers,
- traveler's diarrhea,
- bacterial prostatitis, and
- chronic otorrhea.

The chart below presents the average wholesale price of a 10-day course of treatment plus a $3 dispensing fee. While prices vary from pharmacy to pharmacy and region to region, this chart provides physicians with a means for making relative comparisons among quinolone antibiotics. The drugs are listed in alphabetical order by brand name. We are also providing cost information on alternative therapies.

For a free pocket card or wall chart version of this information on *quinolone antibiotics*, contact the Society's Center for Professional Drug Education and Information at (800) 228-7823. Pocket cards and wall charts are also available on nonsteroidal anti-inflammatory drugs.

Quinolone Antibiotics: Cost of 10 Days of Therapy

BRAND NAME	GENERIC NAME	ADULT DOSING	QUANTITY	BRAND COST	GENERIC COST
Cipro	Ciprofloxacin	500 mg BID	20	$61.45	NA
Floxin	Ofloxacin	200 mg BID	20	$56.62	NA
		400 mg QD	10	$36.61	
Maxaquin	Lomefloxacin	400 mg QD	10	$59.60	NA
Noroxin	Norfloxacin	400 mg BID	20	$49.84	NA
Penetrex	Enoxacin	400 mg QD	10	$29.00	NA
Alternative Therapies:					
Achromycin	Tetracycline	250 mg QID	40	$3.91	$4.27
Amoxil	Amoxicillin	500 mg TID	30	$15.12	$10.74
Augmentin	Amoxicillin/ Clavulanate	500 mg TID	30	$74.75	NA
Bactrim	Trimethoprim/ Sulfamethoxazole	160/800 mg BID	20	$20.05	$8.75
Ceclor	Cefaclor	250 mg TID	30	$60.38	NA
Cloxapen	Cloxacillin	250 mg QID	40	$17.64	$14.32
E-Mycin	Erythromycin	250 mg QID	40	$12.20	$8.70
Geocillin	Carbenicillin	764 mg QID	40	$67.06	NA
Keflex	Cephalexin	250 mg QID	40	$49.90	$13.72
Macrodantin	Nitrofurantoin	50 mg QID	40	$29.40	$3.73
Pathocil	Dicloxacillin	250 mg QID	40	$19.76	$16.80
Prostaphlin	Oxacillin	500 mg QID	40	$48.20	$24.87
Suprax	Cefixime	400 mg QD	10	$60.15	NA

Notes

Cost = Average wholesale price plus $3.00 dispensing fee.
Dosage and duration may have to be adjusted for disease severity, age, and/or co-morbid conditions.
NA = not available.

Source

1993 Red Book Drug Topics Update. Medical Economics Company, Oradell, New Jersey.

This comparative table was assembled by Health Information Designs, Inc. (HID)—a firm specializing in drug utilization review, based in Fairfax, Virginia—who is a partner in the Pennsylvania Medicaid Retrospective DUR program. *Copyright 1993, The Prescription Drug Education Project.*

Integrated Delivery Systems: One Staff's Experience

James G. Pitcavage, MD

Many hospitals and medical staffs have established a physician-hospital organization (PHO) or are discussing the development of one to facilitate contracting with managed care organizations. Physician leadership is essential in the establishment of a PHO in order for physicians to maintain control over patient care. This article describes how one medical staff—at Sewickley Valley Hospital—formed a PHO with its hospital and then a network with other PHOs. It also explains how physicians play an active role in the organization.

In 1980, physicians on staff at Sewickley Valley Hospital had a number of concerns, among them loss of patient volume and the hospital's interest in recruiting physicians to the area. The administration also had concerns, including market competition from other hospitals and physician loyalty. Both the hospital and the medical staff were concerned about the growth of managed care, a growing trend of shifting economic risk from payers to providers, and a fear that if providers do not find a solution to the rising cost of health care, the government will.

The medical staff and hospital determined that there were a number of positive reasons to establish an organization:

- It would place the hospital and medical staff in a better position to deal with health system reform.
- The organization would be better able to address problems that surfaced.
- It would create economic incentives for the hospital and physicians to succeed.
- Physicians' practice costs would be reduced through bulk purchasing.
- The hospital and medical staff would have more leverage with managed care organizations due to the ability to provide data on cost and quality of care.

Establishing the organization

The medical staff and the hospital established a hospital/physician joint venture (HPJV), which is a forerunner to what is now generally called a physician-hospital organization (PHO).

The HPJV was incorporated as a separate organization controlled by shareholders, with ownership allocated at 50 percent hospital and 50 percent physicians—physicians must purchase a share in the PHO to become a member. The hospital and physicians are equally represented on the HPJV board, and the physician board members are elected by the physician members of the organization.

Initially, membership in the HPJV was offered to the entire medical staff. Potential members were told that credentialing standards would be developed that would be applied to everyone and that those not willing to comply with standards would be asked to leave the organization.

The primary function of the HPJV was to develop opportunities to contract with managed care organizations. It also purchased computers, lab equipment for the hospital and physician offices, and whatever else was needed.

Expanding the organization

The medical staff and hospital found it very difficult to market a single PHO. Because Sewickley Valley Hospital, a small 220-bed community hospital just north of Pittsburgh, does not have sufficient numbers of specialists on staff to provide a full array of services, the hospital and physicians decided to approach other community hospitals in the Pittsburgh area to test interest in forming a network.

In 1985, the ALPHA Health Network, a preferred provider organization (PPO), was founded by Sewickley Valley Hospital and six other community hospitals in the Pittsburgh area, all of which had formed an HPJV with physicians on their medical staffs. ALPHA is a not-for-profit PPO which directly contracts with employers, insurers, and third-party administrators on behalf of its network providers. Its mission is two-fold: 1) to develop a network of participating hospitals and physicians committed to delivering high quality cost effective health care; and 2) to design appropriate methods for

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He wishes to thank Kipton Kaplan, president and CEO of ALPHA, for his input into this article.

quality assessment, patient referral, and utilization.

Organizational structure

ALPHA is made up of HPJVs which are responsible for creating internal procedures for reviewing clinical data and improving provider performance. The ALPHA board, made up of the CEO and a physician leader from each member hospital, provides governance and leadership and establishes direction for ALPHA's managed care initiatives. ALPHA has a Medical Advisory Group (MAG) and a Quality Assurance and Improvement Committee.

The MAG, which is made up entirely of physicians, develops the credentialing standards for all physicians who belong to ALPHA. It also:

- defines medical policy for the HPJVs;
- provides a link between the HPJVs and ALPHA;
- reviews network needs;
- decides what clinical services ALPHA can and cannot provide, and should and should not provide;
- develops the medical criteria for use in utilization review;
- serves in an advisory capacity to ALPHA management and utilization review nurses; and
- serves as an appeal board for all determinations of inappropriate care for payers who utilize the ALPHA medical management process.

ALPHA's Quality Assurance and Improvement Committee is a subcommittee of the MAG, comprised of at least one physician from each hospital in the ALPHA network and a quality assurance coordinator. Its responsibilities are to:

- review and analyze outcome data, and present its findings to the MAG (the MAG has authority to go back to the HPJV if there is a problem);
- determine methods for corrective action;
- design programs to educate physicians, nurses, and hospitals depending on where the problem lies; and
- look at best practices and best results.

The Quality Assurance and Improvement Committee uses MedisGroups data, claims information, hospital reports, and medical charts to compare acceptable standards and the medical results of each network physician and hospital. When a need for improvement is evident, ALPHA providers are counseled by their peers to modify their practices and procedures, or pursue alternative methods of treatment. When hospitals and physicians demonstrate superior medical outcomes, other providers in the network are encouraged to use this information to improve their own patterns of treatment.

Benefits of establishing a network

Establishing the ALPHA Health Network has been very beneficial to Sewickley Valley Hospital and its medical staff. It provides the specialists needed to effectively compete for managed care contracts, as well as a vehicle for information sharing and collaborating among hospitals and medical staffs. Sewickley Valley Hospital was able to improve its pneumonia outcomes as a result of this information sharing.

The network has also enabled the medical community to provide wellness and immunization programs, and weight and high blood pressure clinics, which are difficult for physicians as individuals to provide.

The ALPHA network has also been successful in the western, central, and northeast regions of the state. It is the thirteenth largest provider-sponsored PPO in the nation and serves over 147,000 enrollees across Pennsylvania. ALPHA's members include over 2,000 physicians, 16 member hospitals, and more than 50 contract facilities for specialty, ancillary, and diagnostic services.

Managed Care Resource Kit Available

As physicians' involvement with managed care increases, so does their need for information and guidance. The State Society has created the Managed Care Resource Kit to give physicians a condensed source of knowledge that can contribute to survival and success in a managed care environment.

The kit is free and available only to Society members. For content information or to order, call the Department of Physician Services at (800) 228-7823 or (717) 558-7750.

How ALPHA Functions

ALPHA is a not-for-profit preferred provider organization (PPO) that directly contracts with employers, insurers, and third-party administrators on behalf of its network providers. It does not process claims or underwrite benefits, but does provide the claims administrator with all cost documentation required for timely and efficient claims processing.

Contracting process

ALPHA facilitates the process of establishing relationships with multiple payers. To accomplish this, network providers grant ALPHA a limited power of attorney to negotiate contracts on their behalf. The fee schedule used by ALPHA was developed and is maintained by an independent third party designated by ALPHA. Contracts negotiated cannot differ substantially from a master agreement approved by the providers. Additionally, each contract includes an "opt-out" clause which a provider can use if a payer cannot accept the standard agreement. If ALPHA negotiates a contract that differs from the standard agreement, the providers in the network are notified of the changes in writing and given the opportunity to accept or reject the contract. Individual physicians and PHOs are not prohibited from contracting with other third parties.

Utilization management program

A utilization management program was established by ALPHA and its hospital/physician joint ventures (HPJVs) to control the cost of health care services available to purchasers from network providers. A primary component of this program is the Benefit Management Service (BMS). This service is staffed by registered nurses who counsel individuals regarding cost effective procedures, and direct patients to ALPHA member hospitals and physicians. Also, they answer specific questions and assist in patient referrals. A payer may define its own utilization program which may or may not be administered by the BMS.

Negotiate from Strength: Physician-Led Integration

The Health Care Group

Health system reform is likely to be a complex process that will take place over a number of years—not in a single bill passed by Congress. As this process unfolds, market forces are already changing the way physicians practice medicine.

In response to the new realities of medicine—including the proliferation of capitation payments, utilization reviews, and emphasis on outcomes management—hospitals, physicians, and insurers are reevaluating their traditional business relationships and positioning themselves most effectively for a sea of change.

Employer initiatives

Many of these new alliances have become quite visible, such as employers in major cities who have begun to mandate change. Eager to achieve cost-effective health care, large employers are negotiating directly with selected hospitals and doctors. These companies want to secure a package of services based on high-quality standards at a fixed price. If the provider is unable to accommodate them, they simply look elsewhere in the market.

In Rochester, New York, for example, pressure from companies like Kodak, General Electric, and Bausch and Lomb is accelerating the acceptance of managed care—and even creating a "lock-out" for some medical groups. Using community-rating, these companies are mediating between medical groups and insurance companies to contract for services at a competitive price. As a result, the city of Rochester boasts the highest health maintenance organization (HMO) enrollment in the country—54 percent, according to a Group Health Association of America report released a year ago.

Hospital-directed groups

Hospitals across the nation are also taking an active role in shaping new formats for aligning themselves with physicians. Motivated by the fear of exclusion and loss of control (or even existence) in a capitated environment, many hospitals are acquiring practices at a rapid pace. With advantages of capital resources and information to cement these relationships, hospitals are also successfully enticing physicians to join hospital-based networks such as physician-hospital organizations (PHOs) or management service organizations (MSOs).

However, these models are often designed to primarily serve hospitals' interests. In these types of organizations, most policy and strategy decisions are made with the hospital's priorities in mind—not the physicians'. Designed with 50/50 hospital/physician representation on the board, the appearance of fairness is maintained. But when key questions are presented, the hospital representatives are likely to vote as a block, and at least one physician is likely to "defect."

While many hospitals have enticed doctors into joining a hospital-based network by focusing on fear of exclusion, the "sales-pitch" that doctors need hospitals in today's changing environment is misleading. After all, hospitals are essentially *physician-driven*, and doctors make all the decisions on patient care. Doctors make hospitals efficient, not vice-versa. They fill beds, and order laboratory services and tests. Patients—more often than not—are loyal to their doctor, not a hospital.

Moreover, aligning oneself with one specific hospital carries certain risks. In a capitated environment, where hospital stays are minimized and outpatient procedures are maximized, signing on exclusively with a hospital that may not stay financially secure could seriously jeopardize your financial viability. On the other hand, a physician with multiple hospital alliances may be seen as not on anyone's team and thus risk being excluded from each hospital's efforts at integration.

Physician-led integration

Given the surplus of beds and the resulting precarious nature of a hospital's economic stability in a capitated environment, physicians need to take control of their own destiny. In hospital-based affiliations, hospital administrators will ultimately need to place organizational needs ahead of physician needs. By taking the lead and forming physician-led, -directed and -controlled groups—whether they be very large single-specialty groups, multi-specialty

Society Offers Integration Expertise

The professional staff of the Pennsylvania Medical Society is ready to assist counties societies, hospitals medical staffs, and other physician groups in understanding the complexities of developing integrated delivery systems.

The Society has formed Penn Med Members Services Company to consult with physicians on taking the lead in integration. Also, speakers from the Society's Policy and Programs, Governmental Affairs, and Professional Relations divisions are available to make presentations to various-sized groups.

For more information, call the Society at (800) 228-7823 or (717) 558-7750.

groups, or all-inclusive physician networks—doctors can secure market share and maintain full professional autonomy.

Not only do these types of groups control clinical and professional decisions, they significantly strengthen their financial and bargaining power when negotiating with other groups, such as HMOs, insurers, and hospitals. While it is sometimes difficult to overcome old distrusts, when physicians understand that they can have a voice in how care will be delivered and how finances are handled, they will readily move into an integrated system.

An example to emulate

While many physician groups are forming and gaining momentum, the Mullikin Group, based in Los Angeles, is particularly noteworthy. Starting with 35 doctors in 1991, this group has grown into a mega-practice of 3,000 employees that is physician-led, -controlled, and -directed. The group merged medical groups all over Southern California under a physician ownership model that hasn't, until recently, involved an outside hospital, health system, foundation, or public offering.

One of the keys to their success is their heavy base of primary care physicians—nearly 60 percent. This group is enjoying the advantages of significant geographic scope, heavy concentration of primary care physicians, and leverage in negotiating with HMOs. In short, they are putting together the deals with hospitals, and they are steering the ship.

Other groups, such as the Mayo Clinic, Geisinger System, the Texas Back Institute, and the Cleveland Clinic, have earned superior clinical reputations as they capitalize on economies of scale. More importantly, these groups share a vision of how physicians view their role in the coming years, and an understanding that initiating change gives them more control than waiting for change to happen to them.

Be a reformer

The message here is simple. Be a reformer. And be first. If hospitals set up a network before you do, you will be fighting two battles—payers on one front and competing health plans on the other.

An organized group of physicians with convenient, high-quality products has tremendous clout and appeal. Controlling your own destiny through physician-led integration carries with it some risk—but it is not really as risky as ignoring change or waiting until change takes place without you.

The contributing authors, Geoffrey T. Anders, JD, CPA, CPBC, and Michael J. Parshall, are consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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More Details: Governor's Proposal Scrutinized by State Society

In the year since announcement of Governor Casey's health system reform proposals, much state as well as national debate has occurred. Last issue, we began a synopsis of the State Society's most recent responses to the governor's proposals, Senate Bill 1202 and House Bill 1958. This is a continuation of that discussion of specific aspects of proposed reform plans for the commonwealth.

Insurance Market Reform

Under the governor's plan, health care networks would be subject to insurance market reforms that have become virtually standard in health system reform proposals: open enrollment, guaranteed continuity/renewability, a pre-existing condition exclusion prohibition, and community rating. Networks also must enroll a demographic cross-section of the population of their region.

The State Society supports insurance reforms of this nature. The regions would permit limited geographic adjustments. Consideration should also be given to allowing for age adjustments—to avoid dramatic premium increases for young persons.

One of the few advantages of experience rating and medical underwriting is that they provide some incentives for employers to offer employee wellness programs and for employees to live healthy lifestyles. New incentives will need to be put in place when community rating is required. For example, we support a premium surcharge for smokers. Plans should also be permitted to give discounts for healthy behavior and participation in wellness and early screening programs.

We further support the development of innovative insurance products such as permanent (pre-funded) health insurance. It has the potential to be less expensive in the long run, as income earned on the subscriber's equity can be used to reduce or eliminate the premium over time. The equity could also be used to pay the premium during short-term periods of unemployment.

Bureaucratic Intervention

Premium controls

The Health Security Board must approve the rates charged by health care networks. The board could modify rates and establish an index limiting yearly rate increases.

The Casey proposal includes many elements similar to those in the "managed competition" model—a health system reform model designed to control costs through competition. However, the proposal also includes a number of provisions that evidence a lack of confidence that competition will be effective in controlling cost. The premium controls are one example.

Physicians are eager for a reformed health care system in which we can compete on the basis of both price and quality. We also have long advocated a number of other measures that would bring health care costs under control, including tort reform, cutting government red tape, slicing administrative paperwork and hassles, and promoting healthy lifestyles.

However, the Society opposes global budgets—set through premium controls or otherwise—especially inflexible, arbitrary caps that are based upon economics, as opposed to the health needs and demands of the population. Premium caps do not correct the underlying causes of rising costs, and will inevitably result in arbitrary rationing and reduced quality and access.

Underserved areas

The Health Security Board is authorized to take several actions under the pretense of stimulating competition in underserved areas, including financial incentives to encourage providers to locate in underserved areas, exclusive service franchises, regulation of provider payments and capital expenditures on plant equipment, and recommendations for preferential treatment of certificate of need requests.

We oppose exclusive service franchises and regulation of provider payments. Both unduly restrict competition and free-choice. Moreover, history has repeatedly proven that price controls are not effective in controlling costs and inevitably lead to harmful results, including reductions in quality, access, and investment in facilities and new technology. In sum, these measures simply replace one set of problems with a worse set of scenarios.

Instead, the board should stimulate competition in underserved areas by providing grants and loans to encourage the formation of physician networks in these areas.

Quality Assurance

Under the governor's plan, health care networks would be monitored and regulated in a manner similar to health maintenance organizations (HMOs) in the existing system. The proposal also relies heavily on the collection, analysis, and public dissemination of outcomes data to protect quality.

As noted, the Casey proposal is a variation of the "managed competition" model, with a heavy emphasis on "managed." Both the bureaucratic intervention aspects of "managed"—especially the premium controls and the mandated managed care—and the premium bidding wars that may result from "competition," raise quality concerns that demand close scrutiny of the promised quality assurance components. For the reasons discussed below, we believe that quality assurance components of the Casey proposal are inadequate. Quality cannot be assured without both scientifically sound health outcomes data and safeguards to protect against networks sacrificing quality to reduce costs.

Network "report cards"

The Health Security Corporation would assume the authority and

responsibility of the Pennsylvania Health Care Cost Containment Council (PHC4), and provide enrollees with cost and quality information similar to the report cards in President Clinton's proposal.

The Society supports the collection, analysis, and appropriate use of health outcomes data. However, we have several concerns:

- It is critically important that outcomes data be comprehensive, accurate, and reliable. Otherwise it does not serve any useful function, and will lead regulators and consumers to make arbitrary decisions based upon invalid data. While many of our initial concerns with PHC4 data have been resolved—especially since the creation of a technical advisory committee—the usefulness of the current data reports is limited.
- The problems with current PHC4 data are largely due to the imperfect state of the art. Although considerable advances have been made in outcomes measurement, and the data from many systems can be very useful in educational feedback programs, the current state of the art has not reached the point that outcomes data can be used to truly measure or compare quality.

For example, current PHC4 data does not adequately adjust for severity. In addition, the mortality data heralded by PHC4 tells little about other important outcome considerations such as morbidity (complications) and the general quality of life faced by the patients who survive. Reliable measures of these other considerations have yet to be developed and more research is needed.

- While we are optimistic that research will enhance the effectiveness of current outcomes measurement techniques, even future refinements may be inadequate. Indeed, quality of life may never be reliably measured. The quality of a patient's life cannot be evaluated by simple blood pressure readings and other objective tests. Quality-of-life evaluations require a host of complex and often subjective considerations that may be impossible to translate into a uniformly applied, numerical system for computerized comparisons.
- Outcomes data must be released to consumers in a format that is readily understandable to people from a wide range of educational backgrounds. The need for consumer understanding is especially critical now, since the current state of the art severely curtails the legitimate uses of the data.

Limited quality safeguards

Health care networks would be required to be licensed as HMOs, have a quality assurance plan that looks at both over- and under-utilization, and contract with a sufficient number and variety of providers, including primary care physicians and pediatric specialists.

The techniques and incentives employed by managed care systems to reduce inappropriate utilization can also jeopardize appropriate utilization when adequate safeguards are not in place. Consequently, safeguards are essential to ensure that managed care efforts to control insurer costs do not sacrifice quality and access.

These safeguards must include preventive, prospective measures—not just the after-the-fact review provided by data analysis. As discussed above, current quality measurement systems are imperfect and may never be developed to the stage that quality can be truly measured—let alone effectively used by consumers.

In any event, it will take time to identify and eliminate plans that provide poor quality care. In the meantime, patients may be irreversibly injured by the denial of medically appropriate care.

We are pleased by the inclusion of some prospective safeguards in the governor's reform proposal. However, far more protections are necessary. The proposal ignores many of the safeguards that we recommended in our managed care paper, including those pertaining to credentialing of network providers, utilization review, and reimbursement incentives.

Practice Parameters

The Health Security Board is charged with coordinating the development and implementation of practice parameters.

We support the development of practice parameters. They have the potential to both increase quality and reduce costs. However, we have several concerns—including the lack of safeguards to assure appropriate development and use.

- Practice parameters are guidelines—not standards of care. They should not be adopted as a clinical rule or used as a per se indicator of a quality or utilization problem, except in limited situations where variation is deemed by the preponderance of medical opinion to be inappropriate in any clinical situation. Physicians and other medical providers generally must be given the leeway to deviate from practice parameters when their patient's unique condition warrants a different course.
- While the potential of practice parameters is promising, they also have limitations and are untested. The management of many patients is not conducive to even general definition. In addition, practice parameters have yet to be extensively tested and might backfire.
- The board's role and responsibilities need to be better defined. The success or failure of the current and future parameters will also rest on the development process. Proper development demands research of the relevant scientific studies, practical clinical experience, and expert opinion. Parameters also must be regularly reviewed and updated to ensure that they remain relevant and do not hinder medical progress. Physician organizations must be included in the process. They possess both the requisite knowledge and the broad-based representation necessary to achieve consensus.

Limited Administrative Relief

The Health Security Board would be required to establish uniform explanation of payment forms for use by health care networks when they reimbursed providers.

We have advocated a uniform explanation of medical benefits form for some time. However, the proposal does not address the full scope of administrative relief the Society has advocated to reduce administrative costs resulting from claims processing and managed care requirements. "Hassle" protections are especially critical in the governor's proposal—as the mandated managed care requirement is likely to intensify hassles.

Reform Debate Touches Pennsylvania

David Woods

The campaign to foster support for President Clinton's health system reform plan is making headlines around the nation. A recent stop by Clinton officials at a Philadelphia forum generated this report. More than 400 people representing the medical profession, insurance industry, and public attended the forum entitled, "The Health Care Dilemma: Problems at Home, Lessons Abroad?"

The United States is attempting to restructure a health care system which, at close to one trillion dollars a year, equals the world's eighth largest economy, according to William Kissick, MD. He told participants at a February 15 forum, sponsored by the World Affairs Council of Philadelphia, that the system can expect to fulfill only two of the three criteria of access, quality, and reasonable cost.

Dr. Kissick, professor of public health and preventive medicine at the University of Pennsylvania, and a professor of management at the Wharton School, was one of two physicians who helped draft the original Medicare legislation. He described that legislation as having failed to detect three trends—technology, utilization, and demography.

Noting that the United States now spends considerably more on health care than on education, Dr. Kissick said that by the year 2000 we'll have a well-medicated but illiterate population whose economic ascendancy will have been eclipsed by Japan, Korea, and Germany. Since no society is capable of providing all of the health services a population demands, he said, choices will have to be made in any restructuring of health care. He predicted an end to fee-for-service solo practice, a shift in medical education towards production of more primary care physicians than specialists, and the use of nurses to treat the elderly.

Whatever the challenges of health system reform, "at the end of the day," the Clinton plan will be adopted, keynote speaker Ira Magaziner told the meeting. Magaziner, senior adviser to the president for policy development and principal strategist for the health system reform package, said that the much-criticized strategy of presenting a detailed—1,300 plus—page report was so the people know what's being proposed. Past efforts at social reform, he said, have been presented in skeleton form and then subjected to 10,000 pages of regulations.

Acknowledging that there are items that may be unwise in the bill, or that can be improved upon, Magaziner said that the underlying principles of reform will be enacted. Those principles, he said, are:

- universality;
- community rating, so that age and health status don't affect eligibility or cost;
- comprehensiveness;
- control of the rate of cost increases;
- choice (of plan and of physicians);
- simplicity (one universal claim form);
- quality—what Magaziner called moving away from the micro-management of "checkers checking the checkers checking the checkers" to outcomes-based criteria; and
- responsibility (an emphasis on primary and preventive care).

Magaziner said that a cap on the growth of premiums would put some discipline into the system, and increased competitiveness would "put the consumer into the driver's seat."

Noting that the Clinton health system reform team has seen 1,400 different special interest groups, Magaziner concluded that change won't be easy—"It'll be like a hurricane on a roller coaster"—but that we're going to have reform because the people want it.

Later, at a panel discussion on what Americans could learn from other countries, Ontario Medical Association president Tom Dickson, MD, said that government imposition of "hard caps" on hospitals and physicians has meant that fee schedule increases for Ontario doctors will work out to 0.8 percent a year from 1988 to 1996. As the U.S. moves to broaden coverage, the Canadians are moving to narrow it, said Dr. Dickson, with the "de-listing" of procedures such as routine newborn circumcision and reversal of sterilization.

He warned that U.S. physicians should jump right into the debate on health system reform, lest they be the object of the same kind of unilateral decisions about their professional lives as has been the case in Canada. In 1993, he concluded, a record 650 Canadian physicians emigrated—a luxury that presumably their American counterparts do not have.

The author is president of Healthcare Media International, Inc., Philadelphia, and a former editor-in-chief of the Canadian Medical Association Journal.

AMA STUDY SHOWS GROWTH IN GROUP PRACTICE

With health system reform on the horizon, a third (33.4 percent) of American physicians in the direct care of patients are now involved in group practices, compared to 18 percent in 1969, according to a new AMA study.

"Physicians in Medical Groups: A Comparative Analysis 1993" finds that physicians in group practices—defined as three or more physicians—feel less restrictions on their autonomy, are more likely to be board certified, more likely to contract with health maintenance organizations, and tend to have somewhat higher incomes than physicians in solo and other practice settings. The study sees the trend toward group practice accelerating under health system reform.

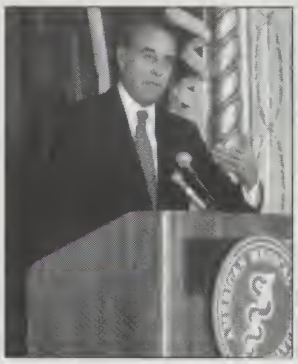
The study also finds a third (34 percent) of American physicians still

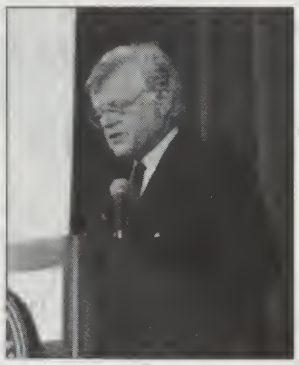
in solo or two-physician practices, while 32.6 percent practice in other patient care settings, such as hospital employment or under temporary employment arrangements.

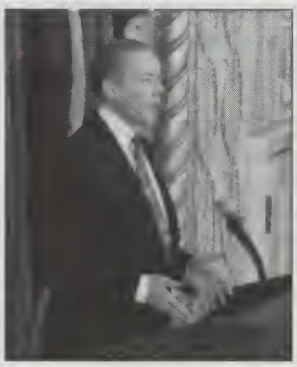
Those in group practices report seeing more patients than their colleagues in solo or two-physician practices, according to the publication. Their patients, on the other hand, wait longer for appointments and longer in waiting rooms.

The study further investigates the demographic and professional characteristics of physicians in group versus solo or two-physician practices, and examines relationships to different managed care environments, such as the presence of an HMO or PPO contract and perceived clinical autonomy.

For more information about "Physicians in Medical Groups: A Comparative Analysis 1993" (AMA publication OP#392993CH), call the AMA at (800) 621-8335.







Senators Bob Dole (R-KS, top left), Orrin Hatch (R-UT, bottom left), and Edward Kennedy (D-MA, top right) were among several U.S. congressmen and AMA leaders to address health system reform at an AMA rally, "Partnership in Action: Uniting for America's Health," held on March 8 in Washington, DC.

Senator Dole said that while he doesn't think the health care system is in a "crisis" yet—i.e., it is not ready to collapse—he does believe some sort of a reform bill will pass Congress this year. He didn't elaborate. Senator Hatch, however, believes the U.S. system is on the verge of catastrophe, and he is concerned. He said the "wrong decision" about reform "will set us back" for a long time.

Senator Kennedy, in an interview with *American Medical Television,* said he "hopes doctors realize that this is an opportunity to get comprehensive health care passed. There will never be a balanced budget in the U.S. until health care costs are under control."

Members of the Society's board and alliance, as well as other physician leaders from across the U.S., attended the event. **For commentary, see page 6.**

Reform Resources Available from the Pennsylvania Medical Society

- **Exploring the Issues in Health System Reform.** Full-color brochure designed to help Pennsylvania physicians talk to their patients. To order, call the Division of Communications and Public Affairs at (800) 228-7823.

Reform Resources Available from AMA

The following health system reform materials are available at no charge to physicians through the AMA Health Policy Resource Center. To order, call (800) 262-3211.

- **Providing Health Coverage for All Americans: Health System Reform Proposal for Action.** 8-page booklet. Publication #101.
- **A Message to My Patients: We Need a Better Health Care System.** 4-page patient education brochure. Publication #102a. (A packet of 25 copies of the brochure is also available. Ask for #102b.)
- **Moment of Trust Ads.** Four different 8½ x 11 ads calling for reform. Suitable for framing or copying. Publication #103.
- **AMA Analysis of the Clinton Plan.** 25-page, side-by-side comparison with the AMA position. Publication #104.
- **Comparison of Congressional Health Reform Proposals.** 83-page, side-by-side comparison. Publication #105.
- **Advocacy Briefs.** Provide responses to frequently made statements and give supporting arguments. Topics available: U.S. and International Health Spending (#111), Health Reform Glossary (#112), The Impact of Violence (#113), Medical Technology (#114), Physician Income (#115), and Professional Liability and Access to Care (#116).
- **Policy Briefs.** Outline issues and background information. Topics available: Health Care and the Economy (#117), Administrative Costs (#118), Price Controls in Health Care (#119), Managed Care Plans (#120), and Nurse Practitioners and Physician Assistants (#121).
- **Fact Sheets.** Topics available: How U.S. Health Dollars Are Spent (#131), Estimated Health Care Costs Related to Lifestyles (#132), Who Pays? (#133), and The Insured and the Uninsured (#134).

PMSLIC: Focusing on Physicians' Needs

Betty L. Cottle, MD

The malpractice world is changing, and physicians are asking: How do I choose the right carrier for me? To help physicians answer that and related questions, the chairman of the board of the Society's liability insurance company offers this overview of the company's basic philosophy and focus.

As new carriers enter the malpractice insurance market, and others market more aggressively in order to compete, there may be a growing sense of confusion among physicians: Should I care about a rating by some organization I know nothing about? What does it mean to me to have a consent provision? How can these rates be so much lower? Which carrier will best represent me and my interests?

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) is the answer. As the wholly owned subsidiary of the State Society, through its subsidiary PennMed, we are the carrier focused on physicians' individual needs, as well as those of the physician community.

We were formed when physicians needed a carrier that could be there through thick and thin, and we were capitalized by contributions of the State Society's members. Our board of directors consists exclusively of physicians, with the exception of the president of the company and the executive vice president of the Society, and, as a result, board committees are comprised of physicians practicing medicine in Pennsylvania. Our operating decisions are made by physicians. PMSLIC is committed to Pennsylvania physicians. We are here for the long term.

We take every appropriate step to minimize the costs of liability insurance, and many of the steps we take are a direct challenge to the status quo. We operate on a not-for-profit basis using all investment income to offset expenses for our physician insureds. This operating philosophy has been recognized by A.N. Best, one of the premier "rating" organizations, which rates PMSLIC an NA-4.

An NA-4 rating is assigned to a company "when the nature of its business and/or operations is such that our normal rating procedure does not properly apply." We set out to challenge the industry that had left physicians stranded, and we have done so.

Think of it: The industry failed physicians. Now, companies which follow the standards—the *for-profit* standards—of that very industry trumpet that success as a reason for you to buy their product. That simply makes no sense.

Physicians direct PMSLIC. Physicians who are practicing medicine just as you are; who face the same changes in that practice, the same cut-backs in fees, the same questions about liability and a crazy court system. They look for every prudent way to reduce costs of insurance, for all insureds—including themselves.

Fighting the tough fight

There are many ways to hold the line on costs. First is peer review, with physicians and a carrier willing to fight the tough fight. PMSLIC is a recognized leader in terms of trying the case no one else would try...and winning! We can do so only because we have reviewed the case for medical merit and because our physician insured has been involved in the evaluation from the start.

Physicians make claims and underwriting decisions. Each decision is communicated to the insured *before* action is taken. Every insured has the opportunity to meet with the physicians on the committee to review the decision, and has recourse to an independent body of the Society (Professional Liability Insurance Appeals Committee or PLIAC) for a final determination of an issue. No claim will be settled without the consent of the insured or a final resolution from PLIAC.

There is no question that PMSLIC is the quality carrier. Our claims results match or exceed those of other carriers. Our coverage is geared to all aspects of the practice of medicine. We have stayed true to our philosophy of identifying meritorious claims and moving expeditiously to resolve same while vigorously defending all claims which lack medical merit. We have always been willing to pay the defense costs associated with defending even the smallest monetary value claim. No claim is "small" in the eyes of the physician defendant.

Dr. Cottle is chairman of the board of the Pennsylvania Medical Society Liability Insurance Company.

Sometimes, of course, physicians prefer to settle claims even when they believe that the medicine was appropriate. The advent of the National Practitioner Data Bank, increased use of managed care entities which appear to credential based on economics or superficial claim analysis, and increased activity by hospitals to buy practices and bring physicians within their fold, all cry out for a carrier which represents the interests of physicians.

We believe that physicians and medical staffs must have input and collaboration in the process of medical malpractice defense: This is a cornerstone of our existence. Also, we believe that physicians should be involved in the defense of a claim throughout the process. At PMSLIC, no defense counsel firm is approved until interviewed by the Claims Committee, made up of eight physicians. We pride ourselves on the monitoring, quality, and relationship we have with these firms.

We avoid tying ourselves to a single firm. It is essential to have a number of law firms available to represent the unique needs of physicians.

We constantly look for different ways to approach litigation. There is no single answer which always works, and the paramount need has to be to fully represent the interests of each and every insured—which sometimes, simply put, costs a lot of money.

We have developed a reputation for standing by our decision to defend good medical care—trial judges and plaintiff trial lawyers throughout this commonwealth know that PMSLIC means business. We firmly believe that the costs associated with defending good medicine are a sound investment, not only because we are protecting the interests of our physician insureds, but also because it reduces the number of claims, particularly those with doubtful liability.

Risk management

Another method of cost reduction is to reduce the risks of practice. Our risk management programs are unsurpassed. Expert medico-legal advice is just a phone call away. We offer educational programs which have been purchased by other physician groups and carriers. PMSLIC focuses on supporting physicians as they encounter the uncertainties of practice and the often bizarre impact of the legal system upon the practice of medicine.

To encourage participation and education, we offer programs for premium discounts and Category 1 CME credits, a risk management newsletter, reports identifying specific risks based on nationwide statistics and results; the Laws and Regulations Affecting Medical Practice, and many other materials and services.

More dividends

Yet another method of cost reduction is the payment of policyholder dividends. These dividends reflect our dedication to charging the right rates and returning any amount not needed to the insureds. This year, we declared our third policyholder dividend in the amount of 10 percent of premium.

One might ask why other companies are offering some physicians rates substantially lower than PMSLIC. The answer is simple. A look at the rates filed with the Insurance Department shows that all filed and approved rates for the major carriers are in the same range. That means that rates supported by actual claims experience are substantially the same.

Right now, some carriers are offering discounts of 30-40 percent routinely! But if the rates filed with the department are correct—and they are based on each company's own experience—then the discounted amounts being charged under these programs cannot be based on this experience. The last time this industry was so driven was in the seventies, and we all know what happened then.

One-stop shopping

Of interest to many is that we offer "one-stop shopping" through our membership in the Pennsylvania Medical Society family. In addition to our professional liability insurance, the Society offers a full program of other insurance products. A simple review of the publication "Resource Guide for Pennsylvania Physicians," mailed to every member, will outline the many products and services available. One need look no further than the family of the Pennsylvania Medical Society to meet all practice needs.

PMSLIC has been chosen by more independent practicing physicians than any other carrier in Pennsylvania, because of our quality, our advocacy for physicians, and our financial strength. Choosing another carrier may save money in the short run, but talk to your colleagues who are returning to PMSLIC after a stint with a low-cost carrier because they received unsatisfactory representation on a claim, or inflexibility in underwriting, or lower quality service. Is your practice and the protection of your assets something you will leave to the lowest bidder? ⬡

"The real world is that managed care is here... Capitated payments limit what doctors can do and will encourage more medical malpractice... reform without liability reform is a mirage, and it 'ain't gonna happen.' "

—Dr. Cottle, to the state's Senate Public Health and Welfare Committee at its February meeting on medical liability reform

Recognizing the Uncertainty of Medicine's Future

Maria T. Montesano
Assistant Managing Editor

Next month
Look for profiles of newly elected resident physician, Joyann A. Kroser, MD, and newly elected medical student trustee, Stacy L. Krisher.

In this second of three articles profiling the State Society's newly elected board members, John R. Martell Jr., MD, Young Physician Section trustee, discusses his medical training, his trustee position, and the importance of physician involvement in organized medicine.

Five years ago, John R. Martell Jr., MD, took a long, hard look at the future of his profession. Seeing overwhelming changes and the uncertainty of practicing medicine into the twenty-first century, he decided to join the federation of medicine—to get involved. "If you're not part of the solution," he says, "then you're part of the problem." Today he's committed to being part of the solution: He represents young physicians as a trustee to the State Society's board.

Dr. Martell joined the board last July, replacing Richard J. Greco, MD, who moved out of state before his term expired. Dr. Martell says he sought the trustee position because he feels it's important that young physicians have a voice in organized medicine. "We're the ones who are going to be facing whatever changes are made, and we need to have a voice in the decision-making process," he says. He was officially elected to the position by the Young Physician Section at the October annual meeting.

Dr. Martell

Training in medicine

Dr. Martell, a native of Elizabeth, says he was focused on a career in medicine by the time he got to high school. He received his bachelor's degree in biology from the University of Pittsburgh and his medical degree from Jefferson Medical College of Thomas Jefferson University.

He then served eight-and-a-half years of active duty in the U.S. Army, including an internship at William Beaumont Army Medical Center, El Paso, Texas, and a residency in orthopedic surgery at Dwight D. Eisenhower Army Medical Center, Fort Gordon, Georgia. He says he chose orthopedics because he enjoyed surgery, and orthopedics offered "a full spectrum of treating the musculoskeletal system."

One of his strengths as an orthopedic surgeon, he says, is his ability to "think" in medicine—a concept he learned from Anthony Ballard, MD, one of his professors at Jackson Memorial Hospital in Miami, Florida.

"Dr. Ballard really impressed me," Dr. Martell says. "In a lot of training situations, you are not encouraged to think; instead, you are encouraged to do things the way whoever you're training under does them."

He says Dr. Ballard stressed that the procedure was not as important as the logical thinking that brought his students to a conclusion. "Dr. Ballard would say, 'Present to me what you think should be done, let's discuss it, and if you are right, we'll do it.' Now, with the orthopedic residents at Allegheny General, I follow that teaching philosophy as well," he adds.

As a trustee, he says he is challenged because of his "surgeon's mentality." He explains, "If I identify a problem, I want to fix it,

and it doesn't take me a great many steps to go from point A to point B. But this process isn't always like that. Change often takes years to accomplish."

He believes Society members are often discouraged by that time factor: "They see a problem, and question why we can't fix it or fix it *quicker.* They need to understand the process—that if a law is written, you can't just say it's a bad law. You have to go through a series of legislative maneuvers to get that law taken off the books or changed. It's a challenge for most physicians to understand that, because we tend to be very aggressive individuals...I certainly didn't have a handle on that before I got involved in the Society."

Learning from military medicine

He calls his medical training in the military "excellent, hands-on training, that taught me that I could exist in several different environments."

Over and over again, however, we hear that there is much to be learned from military medicine when it comes to health system reform. Dr. Martell views the U.S. veterans' and military medical systems as "socialistic types of medical practice [that] no one will really look at." He emphasizes one on-going problem he encountered during his Army experience—getting instruments and equipment. "When I would get to a new facility, I would ascertain the equipment I would need to do my job," he says. "But the equipment never got there when I was there. Most of the time, it would come as I was going to my next duty assignment."

"Getting the government more involved in the health care delivery business frightens me," he says. "If you put budgetary constraints on things, then you have to be willing to wait. I don't think the American public is prepared for that."

The Society's most important role in reform, according to Dr. Martell, is to educate its members about managed care options. "Pennsylvania as a whole is probably behind in many areas of managed care," he says. "I know the Pittsburgh area is probably less than 12 or 13 percent managed care, and that has the potential under health system reform to dramatically change. Physicians are not attuned to what those changes are going to mean to the practice of medicine, and we're going to need help sorting things out and understanding the various group arrangements...Joining them will significantly impact our medical practices, and we will have to live with that. The more we understand up front, the less we'll have to regret later on."

The uncertainty of the future

The uncertainty of the future is especially distressful to young physicians, as mentioned earlier—but again, Dr. Martell says education by the Society can help. "I think that, in change, there is an opportunity for younger physicians to control their practice of medicine. I just hope that we are prepared to take advantage of that opportunity."

"I want to see physicians take the lead in reform," he says. "We don't want to diminish the quality of medicine. Health care in the U.S. has to be some of the best in the world, if not the best. I hope that isn't forgotten in the rush to change things. I'd hate to see us move to a system that provides access to everyone at the expense of quality."

He is "somewhat disheartened" that it is difficult to get a group of physicians together on common ground. That makes it easier to separate them—"by specialty, by interest, by everything," he says. "When we were in medical school, we were all the same. And even though we have subspecialized, there has to be a common area that we can all fall back to, and build from there. If we don't, we will be 'pitted' specialty against specialty. Then we'll be doomed to a dismal failure."

Even in the clinical arena, there should be compatibility of specialties: Problems with immunizations shouldn't be a pediatrician's problem, and breast implants shouldn't be a plastic surgeon's problem, he says. "They should be *our* problems, and we should work together to deal with them. That's how you build common ground."

Dr. Martell would like to see physicians step forward and begin to assume responsibility for determining what will occur in the future. He says they need to know they can make a difference and get as many people involved in the political process as possible to ensure that medicine's voice is heard when health system reform hits in final form. "Our members need to be reminded that if they want to get involved, there are many different ways to do so, at whatever level they want—even if it's only at the local level."

But most importantly, regarding health system reform, he says, "We can't forget that our bottom line is taking care of patients. And we can't forget the patients—they have names and faces, they are *not* numbers in a computer somewhere. We can't lose that perspective." ⬡

"I'd hate to see us move to a system that provides access to everyone at the expense of quality."

—John R. Martell Jr., MD

Q&A SUPPLEMENTS NEW STATE HIV GUIDELINES

The Pennsylvania Department of Health in December 1993 released new "Guidelines for Preventing the Transmission of Human Immunodeficiency Virus and Hepatitis B Virus from Infected Health Care Workers to Patients." The following questions and answers are excerpted, with permission, from supplemental department materials.

Do the guidelines affect the responsibility of a health care facility to a health care worker infected with HIV in a manner which differs from the facility's responsibility with regard to any other health care worker?
A facility's responsibility toward an HIV-infected health care worker is, as for all health care workers, to assure to the extent possible a safe and healthful working environment. The guidelines, as well as the Americans' with Disabilities Act of 1990 and the Rehabilitation Act of 1973, preclude discrimination against an individual with a disability, including HIV. The guidelines recommend work restrictions only when there is evidence that an HIV-infected health care worker poses a direct threat to the health or safety of others, and that direct threat cannot be eliminated or reduced to a medically acceptable level with reasonable accommodations.

How can risk assessment be performed, as described in the guidelines, without jeopardizing the HIV-infected health care worker's confidentiality protections?
The Confidentiality of HIV-Related Information Act (Act 148 of 1990) (35 P.S. Section 7601 *et seq.*) imposes a duty of confidentiality upon those individuals who obtain such information while providing any health or social services. Subsequent disclosures are also prohibited without the consent of the subject, absent circumstances which permit disclosure without consent under Act 148 of 1990. Members of the department's expert review panel, as well as members of institutional internal assessment teams, must comply with relevant confidentiality standards.

Do the guidelines recommend mandatory testing of health care workers?
No. Mandatory testing is not an effective or efficient procedure for detecting HIV infection among health care workers. However, the guidelines do encourage health care workers at-risk to obtain HIV testing and counseling.

Under the guidelines, should a health care facility notify patients with regard to a health care worker with HIV or AIDS who has had extensive patient contact?
The guidelines recommend that retrospective notification of a patient is indicated only where there is evidence of significant exposure to that patient. They also recommend that any such notification should not be conducted until the department's expert review panel has completed its own assessment or evaluated the findings of an internal risk assessment team's findings suggesting notification.

Resource for HIV-Infected Physicians

HIV-infected physicians may call the Physicians' Health Programs (PHP) of the Society's Educational and Scientific Trust at (800) 228-7823 for confidential information, referral, and support services.

STUDY INDICATES RADON RISK HIGHER THAN THOUGHT

A new study, reported in the *New England Journal of Medicine* in January, has found that extended exposure to even very small levels of radon in homes can increase the risk of cancer.

Researchers analyzed radon exposures dating back to 1947. They found that residents of homes with 3.8 to 10.8 picocuries of radon per liter (pCi/L) of air had a 30 percent greater chance of having lung cancer, while residents of homes with levels above 10.8 pCi/L had an 80 percent greater likelihood of the disease. The Environmental Protection Agency (EPA) has set 4 pCi/L as the highest acceptable level of radon exposure before remedial action is suggested.

Authors of the article, "Alerting Patients to the Risk of Radon," which appeared in the June 1993 issue of PENNSYLVANIA MEDICINE, feel there is merit to the study. "Our concerns about radon levels from 4 to 20 pCi/L have not been in vain," says Richard T. Bell, MD, a practicing physician in the Reading area and pulmonary representative to the Society's Specialty Section.

"Basically, the results of this residential study correlate to past miner studies," he says. "Originally, it was thought that those studies overestimated the risk of low-level radon exposure. But this study supports the need to test and correct radon levels, and it especially shows the importance of identifying those people at exposures above 20 pCi/L." Dr. Bell concludes, "Clearly, we must pay attention to what was previously thought of as casual exposure."

While EPA statistics show that an estimated seven percent of all U.S. homes are believed to exceed the 4 pCi/L level, state environmental officials estimate that 30 percent of all homes in eastern Pennsylvania may exceed the level due to geological formation.

For more information on radon levels and risks, call the EPA Radon Division Office at (202) 233-9370.

AMA RELEASES HIV, SMOKING GUIDELINES

The American Medical Association earlier this year released new guidelines for the treatment of HIV/AIDS and nicotine addiction. The guidelines provide primary care physicians with new scientific data and strategies for treating HIV patients and smokers during routine office visits, according to the AMA.

The HIV guidelines help physicians diagnose the infection, determine the disease stage, monitor and treat during the early stages of infection, and assist patients in modifying behavior that can transmit HIV. The smoking-cessation guidelines give physicians a step-by-step approach to implement a "stop smoking" program for patients.

The guidelines, endorsed by the Centers for Disease Control and Prevention and the National Cancer Institute, are available by calling the AMA at (312) 464-5372.

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Director, Cardiac Ultrasound Laboratory
Hahnemann University Hospital

Leonard S. Dreifus, M.D.
Director, Division of Cardiovascular Diseases
Hahnemann University Hospital

Kenneth M. Kent, M.D.
Director, Washington Cardiology Center
Washington Hospital Center

Judith L. Swain, M.D.
Herbert C. Rorer Professor of Medical Sciences
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For more information about this symposium, contact the office of Vidya S. Banka, M.D. at (215) 427-7247.

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DISCLOSURE STATEMENT—In accordance with the Accreditation Council For Continuing Medical Education (ACCME) and the Association of the American Medical Colleges (AAMC) Standards and the policy of the Medical College of Pennsylvania, presenters are asked to indicate if they have any relationship which in the content of their presentation could be perceived as a real or apparent conflict of interest, (e.g. ownership of stock, honoraria, or consulting fees). Any such relationships will be disclosed to the audience and consideration will be given to possible influences of their presentation.

Answers to Your Questions About Employee Benefits

John G. Ferreira, Esq.

These answers may take some of the mystery out of employee benefit plan regulation. For a more comprehensive treatment, contact the State Society's Department of Physician Services and ask for "Employment Law: A Guide for Pennsylvania Physicians."

From "ERISA" to "COBRA," from "Form 5500" to "SPDS," from "401(k)" to "415 limits," the universe of employee benefit plan regulation is complicated and highly technical. For a physician-employer, it can be intimidating.

This complexity can discourage physicians from offering benefits to employees—in some cases causing the physicians to lose valuable tax benefits and other advantages.

What are employee benefits?

Generally speaking, they are any form of compensation provided by an employer for services rendered, other than direct wages (i.e., other than salary or other similar payments, like bonuses, commissions, etc.). There are two basic types: pension and welfare benefits, and fringe benefits.

Pension and welfare benefits provide economic protection for employees and their families for major life events, planned and unplanned, such as retirement, termination of employment, pregnancy, illness, disability, death, and education expenses.

"Pension plans" include the usual defined pension plans, money-purchase pensions, and profit-sharing/401(k) plans; "welfare plans" include medical plans, life insurance programs, short- or long-term disability plans, severance plans, tuition reimbursement or educational assistance plans, and dependent care assistance plans.

Fringe benefits permit employees to stretch their paychecks or make their lives more pleasant, healthy, or less stressful.

Who regulates these plans?

For the most part, regulation is federal, through the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code.

Mr. Ferreira is a partner in the firm of Reed Smith Shaw & McClay, Pittsburgh.

Am I required to offer benefits to my employees?

Generally speaking, no, an employer does not have to provide benefits. Of course, health system reform could change this.

If I provide benefits to any of my employees—including myself—must I provide those same benefits to all my employees?

Just as there is no current requirement that you provide benefits to any employees, there is no requirement that you provide the same benefits to all your employees. However, a number of rules under the Internal Revenue Code are designed to discourage "discrimination" in providing tax-favored benefits. The IRS defines "discrimination" as that favoring owner-employees, management employees, or highly compensated employees.

These nondiscrimination rules apply to benefits like tax-qualified pension or profit-sharing plans, self-insured medical plans, group-term life insurance plans, tuition reimbursement, and others.

Under the nondiscrimination rules, if you cover one or more of the "favored" employees, you must generally cover a minimum percentage of the "rank-and-file" employees, giving them comparable benefits. If you don't do this, both the practice and the favored employees may suffer adverse tax consequences—loss of deductions, and/or current taxation of benefits.

The nondiscrimination rules are complicated and differ for each type of benefit. Some allow you to disregard part-time or seasonal employees; others, like the pension rules, require you to count them in determining percentages if, for example, they work at least 1,000 hours per year. Some require you to count "leased" employees—persons from another company who perform full-time work for at least one year in your office for which you pay their company a "fee." The rules may also require you to count employees of affiliated businesses. In

each case, seek professional advice to be sure you're not violating the rules.

What other rules and requirements must I satisfy if I establish a benefit plan?

Other requirements may include:

- a written "plan document" and a plain-English "summary plan description" explaining employees' benefits and legal rights;
- an annual report (Form 5500) filed with the IRS, disclosing various types of financial and other information about your plan;
- if the plan is "funded"—has assets separate from the general assets of the practice, including employee contributions which are not paid over to an insurer—there are a variety of trust, "fiduciary," and "prohibited transaction" requirements concerning the safeguarding and management of the assets;
- if the plan is a tax-favored pension or profit-sharing plan, there are a host of "minimum standards"—minimum participation rules, vesting rules, funding and deductibility rules, rules concerning when and how benefits are distributed, rules to protect spouses, and limits on benefits; and
- if the plan is a health plan, minimum standards rules exist concerning coverage of dependents in case of divorce, coverage of children placed for adoption, etc.; if there are more than 20 employees, the so-called "COBRA" rules require employers to offer continued coverage, at employee expense, when employees or other beneficiaries lose coverage in certain events.

Can I avoid this complexity and risk by just offering benefits on an "ad hoc" basis—my decision as needed?

Maybe. But if you do this more than once, a court might discern a "pattern" of providing a certain kind of benefit. You could then be held to have established a "plan"—such as a severance pay plan—even if you never wrote it down. The next employee in that situation could sue you under ERISA, claiming entitlement to that benefit under your "plan." Federal auditors may find this unwritten plan in noncompliance, which can lead to substantial penalties or excise taxes. If you plan to provide any employee benefits, it's highly advisable to do so in a way that complies with law.

Watch for Seminars in May

John G. Ferreira and Mark Fontana, both of Reed Smith Shaw & McClay, will present a series of seminars on employment law and employee benefit issues in May. Sponsored by the State Society, the seminars will be held May 17 in Pittsburgh, May 19 in Harrisburg, and May 24 in Philadelphia. Contact the Society's Department of Meeting Services at:

(800) 228-7823

for more information or to register.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

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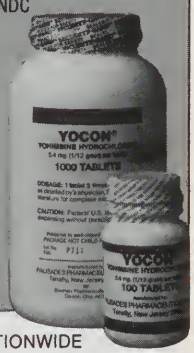

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Emergency Physicians Tackle Violence

Maureen Hoepfer

Richard M. McDowell, MD, is chairman of the Department of Emergency Medicine at Crozer-Chester Medical Center, Upland, and president of the Pennsylvania Chapter of the American College of Emergency Physicians. When he became president last April, Dr. McDowell designated addressing societal violence as a chapter priority. Since then he has been instrumental in the specialty society's efforts to use a public health approach to tackle this problem.

Emergency physicians are firsthand witnesses to the devastating effects of violence in America, and they will tell you that the problem is getting worse, says Richard McDowell, MD.

"We see the victims of violence every day in our emergency departments. We patch them up, send them out, and more keep coming in," he explains. "Our society is becoming more and more violent, with increasing homicides and other brutal crimes. The cause is complicated, and any solution will be complicated as well. However, there is increasing evidence that violence in America is not inevitable and that solutions can be found."

The costs of violence

Dr. McDowell says the data on societal violence show it is a public health problem that must be addressed. A recently published compendium on violence from the American Medical Association provides these frightening statistics:

- More than 16,000 acts of violence are committed or attempted in the United States everyday.
- Homicide is the third leading cause of death among 15- to 24-year-olds. The homicide rate for children and adolescents has more than doubled in the last 30 years.
- More than 1.5 million people in the U.S. are victims of assault each year, and more than 650,000 women are victims of rape.
- 1.8 million women are beaten by their male partners each year.
- Two to four million children were abused or neglected in 1991, and more than one million elderly were mistreated last year.

"The medical costs of violence are enormous in this country. It is estimated that the cost of gunshot wounds alone last year was $20 billion. That's three percent of the total U.S. health care expenditure," Dr. McDowell emphasizes. "In Pennsylvania, the total medical costs of violence in 1991 was $435 million. These statistics don't include the costs of social services, shelters, lost work, and lost productivity."

Public health approach

In a sociologic sense, Dr. McDowell says violence in the U.S. has become an epidemic. "The Centers for Disease Control and Prevention have clearly made the argument that we should treat this problem as we have treated other epidemics in this country: using a public health approach," he explains. The public health approach is to define the problem, collect data, analyze it, identify interventions, and measure their impact.

"Rhetoric will not solve this multi-faceted problem," he says. "What is required is a scientific methodology and an interdisciplinary approach—including physicians, legislators, social services, law enforcement, the judicial system, and others."

When Dr. McDowell assumed the presidency of the Pennsylvania Chapter of the American College of Emergency Physicians (ACEP) last year, one of his first official actions was to appoint a special Task Force on Interpersonal Violence. "I felt strongly that emergency physicians needed to be involved in this issue because we're on the front lines and see the fallout of this epidemic. The mission of this task

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

force is to use a public health approach to study interpersonal violence and develop strategies emergency physicians can use to help reduce the problem."

He admits that violence seems to be such an overwhelming problem that solutions are elusive. However, the issue seems more manageable when focusing on only one or two specific aspects of violence. The Pennsylvania ACEP task force is taking this approach, he says.

Specific strategies

One major task force focus is education. The goal is to inform health care providers on how to better identify and refer victims of violence. "As physicians, we treat victims of violence all the time in emergency departments, as well as in our offices. We need to educate physicians and other health care providers about how to identify victims, how to deal with them, and what resources are available for these patients," Dr. McDowell explains. "I know physicians are not social workers, but we have a responsibility to refer victims to the proper resources for help. I think it's part of the job...it goes with the territory."

To help educate providers, the Pennsylvania ACEP, through its special task force, has published a *Primer on Interpersonal Violence* which it is offering free to physicians and other health care professionals. The primer includes information on how to recognize victims, offer support, and help patients find and use existing resources. "Dealing with victims of violence is difficult for emergency physicians because we like to fix problems and see instant results," Dr. McDowell says. "However, taking the time to intervene and show people where to go next for help is incredibly important in dealing with this problem."

Pennsylvania ACEP will also focus on initiating and influencing legislation related to interpersonal violence, and recently hired a lobbyist to work on this issue. Dr. McDowell says Pennsylvania ACEP will, for example, lobby for passage of legislation which would outlaw the possession of handguns by minors. "Pennsylvania ACEP thinks the legislators need to look at this oversight. We don't believe that children should be allowed to possess handguns. Legislation aimed at selected groups with selected firearms can help reduce the lethality of violence."

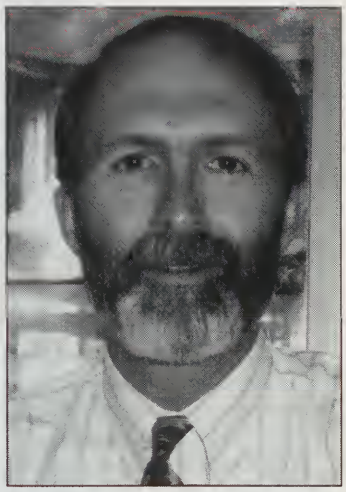
Also, to help educate legislators about the problems caused by increasing societal violence, several Pennsylvania ACEP members participated in a special legislative seminar sponsored by the House Judiciary Committee earlier this year. Issues discussed included the costs of violence, emergency treatment and care of victims, and violence as an epidemic.

"By talking with and educating legislative leaders, we hope to not only influence legislation related to this issue, but also funding. We need to put money into this issue to effectively deal with it," Dr. McDowell explains.

Finally, the Pennsylvania ACEP task force will work on building coalitions against interpersonal violence in Pennsylvania and getting involved in committees working on the issue. Recently, the Pennsylvania Department of Health appointed Dr. McDowell to represent Pennsylvania ACEP on a special Interagency Committee on Violence Prevention. Secretary of Health Allan S. Noonan, MD, has designated addressing violence as one of the department's priorities and has allocated $400,000 for pilot community-based anti-violence programs.

"This task force is a start, but we're hoping to build a strong coalition in the state against societal violence." Dr. McDowell says, "Strong coalitions can have an impact. Look at the success Mothers Against Drunk Driving had on that issue in this country."

"I realize that this problem won't be solved in the year that I'm president of Pennsylvania ACEP. But at least we've begun." He adds, "Physicians, legislators, community leaders, and the public need to say enough is enough. We need to say that the level of violence in this country has escalated and is unacceptable. In my opinion, emergency physicians and physicians in general can be very effective in changing public attitudes about violence."



Dr. McDowell

Resources on Interpersonal Violence

Dr. McDowell suggests the following reading material to physicians interested in learning more about interpersonal violence:

A Primer on Interpersonal Violence
Published by the Pennsylvania Chapter of the American College of Emergency Physicians, 1993. Call (800) 228-7823 to obtain your free copy.

Violence
A compendium from *American Medical News* and specialty journals, American Medical Association, 1992.

Deadly Consequences: How Violence Is Destroying Our Teenage Population and a Plan to Begin Solving the Problem
By Debra Prothrow-Smith with Michaele Weissman, HarperCollins Publishers, 1991.

Violence in America: A Public Health Approach
Edited by Mark L. Rosenberg and Mary Ann Fenley, Oxford University Press, 1989.

Society Saves Physicians $3 Million in Refunds

The State Society, working closely with the AMA, has saved Pennsylvania physicians nearly $3 million in refunds demanded as a result of a payment error by Pennsylvania Blue Shield.

The Society learned of the problem late last summer when Blue Shield sent a refund demand letter to approximately 1,600 Pennsylvania physicians and clinical laboratories. The letter demanded refunds for what Blue Shield characterized as "overpayments" that it had made for two organ panels.

Similar letters were sent to physicians and labs in Blue Shield services areas surrounding the commonwealth with refund demands exceeding $13 million. Pennsylvania's share was over $6 million.

Shortly after the Society learned of the problem, it sent a letter to HCFA expressing its concerns. After months of meetings and correspondence, HCFA has offered in resolution:

- a one-year statute of limitations, as requested by the Society. Refunds now are required only for overpayments made during the one year prior to the administration's discovery of the error on July 24, 1993. Because Blue Shield corrected the error earlier, the applicable refund period actually has been shortened to about 10 months.
- not to seek refunds from physicians and labs overpaid less that $1,600 during the shortened refund period.
- to waive interest on unpaid balances for one year from the date new refund letters will be issued. After that time, interest will be assessed on unpaid balances at a rate yet to be determined.
- to grant requests for installment payments for up to 15 months without demonstrating "hardship," with interest assessed as described above. If hardship can be demonstrated, the payback period may be extended beyond 15 months.
- to require Blue Shield to pay the administrative costs of collecting the refunds.
- to allow another carrier (i.e., not Blue Shield) to handle appeals.

Even with these concessions, it is important to note that *physicians may still contest their liability by filing an appeal.*

The Society's Department of Legal Affairs has prepared information outlining the options available to physicians, and explaining how to file and pursue appeals. To obtain this information—free and available only to Society members—call the Department of Medical Economics at (800) 228-7823, or fax a written request to (717) 558-7841.

RESOURCES OFFERED ON HOLD HARMLESS CLAUSES

Managed care contracts sometimes include a provision that requires the physician to assume the liability of the third-party payer that results from the third party's negligence or otherwise. These provisions are often referred to as "hold harmless" clauses.

While the Society cannot provide legal advice on specific contracts, our Department of Medical Economics can provide background information on these clauses, and our Department of Legal Affairs can discuss legal issues in general terms with physicians. To contact either department, call the Society at (800) 228-7823 or (717) 558-7750. Physicians should consult with their own attorneys for specific legal analysis.

Note: Managed care contracts also routinely include a clause that prohibits physicians from seeking payment (except for copayments and deductibles) directly from the managed care subscriber, even if the payer fails to pay due to insolvency or some other reason. While this is sometimes also referred to as a "hold harmless" clause, it does not raise the same concerns as the clause involving liability.

National Medicare Fraud Alert Issued

Pennsylvania Blue Shield-Medicare has issued the following National Medicare Fraud Alert:

A supplier of durable medical equipment (DME) and supplies is marketing incontinence care kits to other DME companies and directly to nursing homes. The marketing plan states that nursing home patients who are covered under Medicare Part B and who have a diagnosis of urinary incontinence (ICD-9 Code: 788.3) qualify for the kits. In some instances the seller reportedly states that Medicare is paying for the kits under a special pilot program. Reportedly, beneficiaries are frequently told to ignore the copayments if they do not have insurance.

The kits are being presented to nursing homes with diapers included. However, in some instances, the diapers are reportedly given free, in addition to the kits, to the nursing home in exchange for the names and HICNs of beneficiaries. In either case, marketing representatives obtain beneficiary HICNs and order bulk quantities of supplies billed in the beneficiary's name. *However, in no case are diapers covered under Medicare.*

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Governor Proposes 1994-95 Budget Increases

In his annual budget address to the General Assembly in February, Governor Robert P. Casey outlined increases in a number of human service and welfare areas for 1994-95.

"This budget substantially increases our commitment to women, children, older citizens, and families," he told the assembly. "At the same time, it recognizes that unless we change our policy of providing additional state benefits to welfare recipients, these programs face complete extinction. I do not want to see this happen."

He further explained that his proposals limit state-funded benefits to those able to work, with the overall goal of crafting a program which is "sensible, fair, and compassionate."

The governor has proposed:

- $2.55 billion in state Medical Assistance funds to provide outpatient, hospital, medical transportation, and nursing home services for the poor;
- $376.4 million ($2.7 million increase) in state and federal funds for community mental health services, $385.6 million ($5.6 million increase) for community mental retardation services, $97 million ($21.2 million increase) for early intervention programs provided by the Departments of Public Welfare and Education, and $103.1 million ($5.1 million increase) for intermediate care facilities for the mentally retarded;
- $196 million ($5 million increase) Lottery Fund transfer to the Pharmaceutical Assistance for the Elderly Contract (PACE) Program to offset the cost of prescription drugs for 316,600 older Pennsylvanians;
- $160 million ($11.7 million increase) in state funds for aging programs and abuse intervention services;
- $84.1 million for local drug and alcohol abuse programs;
- $31.25 million ($1.5 million increase) to fund AIDS programs;
- $11.35 million ($818,000 increase) for domestic violence and rape crisis services;
- $9.7 million to comply with the requirements of the Americans with Disabilities Act;
- $5.57 million for the governor's Primary Health Care Program, which funds local environmental health programs; a program to increase the number of primary care providers in underserved rural and urban areas; a generalist physician medical school loan forgiveness program; and the rural telecommunications project to link rural health care providers to urban medical centers through automated technology;
- $3 million for women's service programs and women's medical services that provide alternatives to abortion; and
- $842,000 ($17,000 increase) for breast cancer screening services for low-income women.

Although hearings were being conducted, the potential for political change in the Senate at press time left the timetable for budget passage uncertain.

SOCIETY COMMENTS ON SCOPE OF PRACTICE PAPER

In a recent letter to Pennsylvania Secretary of Health Allan S. Noonan, MD, the Society voiced strong objections to two recommendations published in a draft Department of Health position paper on the scope of practice of non-physician health care practitioners.

"Eliminating the Practice Barriers for Certified Registered Nurse Practitioners, Certified Nurse-Midwives, and Physician Assistants in Primary Health Care," drafted by a department work group over the last several months, is intended to establish the state's policy for addressing health care access problems in underserved areas of the commonwealth. The statement will be used in support of a grant application to the Robert Wood Johnson Foundation for monies to pursue the state's primary care initiatives and would also serve as the administration's position on legislation on the scope of practice of advanced practice nurses.

Briefly, the draft position states that there is an access problem in Pennsylvania and that many areas of the state are underserved with respect to primary care services. It cites, among other reasons, lack of sufficient numbers of physicians trained in and practicing primary care, length of time to train adequate numbers of physicians as primary care physicians, and "barriers" preventing the use of advanced practice nurses and physician assistants in the delivery of primary care.

The paper recommends:

- transferring regulatory authority for certified registered nurse practitioners (CRNPs) to the Board of Nursing;
- permitting the Board of Nursing to regulate the signing of prescriptions by CRNPs under a written collaborative agreement with a physician;
- ensuring that all health financing systems permit the use of CRNPs and certified nurse midwives (CNMs) as enrolled providers;
- directing the State Medical Board to clarify the authority of CNMs to sign prescriptions in accordance with a written collaborative agreement with a licensed physician; and
- permitting physician assistants to be employed with limited authority until they have passed the proficiency examination.

The Society in its letter strongly objected to the recommendations relating to the transfer of regulatory authority to the Board of Nursing, and the granting of prescription authority to CRNPs and CNMs, citing:

1) the lack of adequate training of CRNPs and CNMs related to prescribing, and legal and liability restrictions to such proposals; and

2) the need for the State Medical Board to regulate prescriptive authority for nurses as it does for physician assistants.

The Society also indicated that continued support for the primary care initiatives of the department might be re-evaluated, should the draft position paper be published unchanged.

At press time, the Society was awaiting the department's response to these and other concerns.

Donald N. McCoy, the Society's director of regulatory affairs and specialty legislation, contributed to this page.

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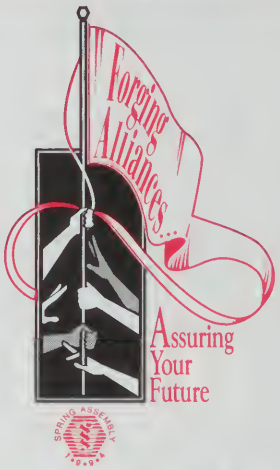
White House Official to Speak at Spring Assembly This Month



Kenneth E. Thorpe, a nationally known economist working with the White House to develop the president's health system reform initiative, is the newest addition to the program for the Society's 1994 Spring Assembly, "Forging Alliances... Assuring Your Future," to be held April 19-20 at the Harrisburg Hilton and Towers.

Thorpe, deputy assistant secretary for health policy in the U.S. Department of Health and Human Services, will discuss the future of health system reform as seen by the White House. His speech will follow Tuesday's keynote address by Richard F. Corlin, MD, vice speaker of the AMA House of Delegates and immediate past president of the California Medical Association. Dr. Corlin will attempt to answer the question, What is the future of the medical profession?

Also, Jennifer James, PhD, a cultural anthropologist, will discuss dealing with the future, and Thomas M. Reardon, Esq., an attorney and one of last year's most popular speakers, will talk about alliances with health care professionals.

Wednesday's program will include six workshops (attendees may pick three) on personal computers, physician-hospital organizations, financial planning, legislative and public speaking strategies, contracting with managed care organizations, and medically futile care.

Assembly activities

In addition to two seminars, "Practicing Politics" and "Improving Cost-Effective Clinical Decision Making," scheduled the day before the conference, the Society is planning several activities in conjunction with the speeches and workshops.

A dinner Tuesday night will feature the Capitol Steps, a nationally known group of political satirists: "The Capitol Steps have been poking fun for 11 years at the high and the mighty, in Washington and elsewhere...Billed as the only group in America that attempts to be funnier than Congress, the Steps came into existence at the beginning of the Reagan administration, when its members, all Congressional aides on Capitol Hill, decided that if entertainers could become politicians, then politicians could become entertainers."

The Steps say they play no favorites in their parodies of Washington's leaders. According to Elaina Newport, co-founder and star of the show, "Typically, the Republicans goof up and the Democrats party; then the Democrats goof up and the Republicans party. That's what we call the two-party system."

The Pennsylvania Medical Political Action Committee (PAMPAC) is sponsoring the dinner.

Also scheduled, a "brown-bag" luncheon on Tuesday in the exhibit area will allow physicians and Hospital Medical Staff Section (HMSS) members to meet and discuss current and common concerns, and peruse the exhibits.

A Wednesday morning breakfast will feature an address by State Society President Martin A. Murcek, MD, and the presentation of the Society's Physician Volunteer Award.

This year's Spring Assembly has been approved for 7.5 hours of Category I continuing medical education credit. For registration information, call the Society's Department of Meeting Services at (800) 228-7823.

STATE SOCIETY PUBLISHES REFERENCE FOR COUNTIES

The State Society in late March distributed to county medical society executives its new "Reference System for County Medical Societies." The kit of information is designed to assist counties with current activities and creating new activities.

Topics addressed are: administration, communications, computers, continuing education, governmental relations, publications, resources, speakers' bureau, and special events. More specifically, the kit offers information on such issues as:

- how to handle difficult phone calls,
- how to build relationships with the news media,
- how to start a mini-internship program,
- how to plan a publication, and
- who to contact for information on various health-related issues.

Also included is a public service announcement on living wills.

The Society will continue to update the Reference System periodically, and new sections will be added as needed. Direct any questions about the kit to the Society's Department of Public Affairs at (800) 228-7823 or (717) 558-7750.

THIRD ANNUAL RURAL HEALTH CONFERENCE SLATED FOR JUNE

"FORMING Community Health Systems—ReFORMING Rural Health Delivery" is the theme of the

Third Annual Pennsylvania Rural Health Conference, to be held June 8-10, 1994, at the Nittany Lion Inn, State College.

Denise Denton, president of the National Rural Health Association, will open the conference with a keynote address. A full-day workshop on community health systems development will follow. The remainder of the conference will consist of concurrent and plenary sessions on such issues as: recruitment of health professionals, teen pregnancy, rural hospice care, networking, health legislation, and the role of mid-level practitioners.

Physicians, hospital administrators, other health care professionals, and health care consumers are invited to attend the conference. For information, write to the Pennsylvania Office of Rural Health, Penn State, 7 Armsby Building, University Park, PA 16802; or fax your request to (814) 865-3746.

DOH RELEASES ANNUAL HEALTH RISK SURVEY

The Pennsylvania Department of Health (DOH) in February released the results of its survey, "Health Risks of Pennsylvania Adults 1992."

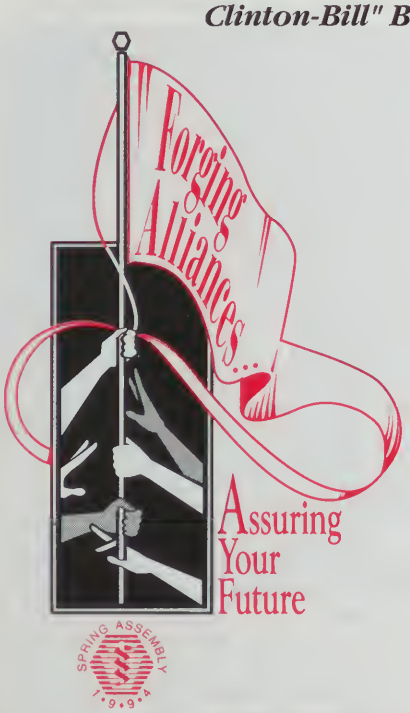
AMA Trustee Paula E. Formica, MD (center), spoke about the AMA's response to the Clinton health system reform proposal at the Berks County Medical Society (BCMS) Installation Dinner, held January 6, 1994, in Reading. Pictured with Dr. Formica are R. William Alexander, MD (left), State Society past president and delegate to the AMA, and Richard T. Bell, MD (right), BCMS past president and alternate delegate to the AMA.

Completed annually by the department, the survey is used to estimate the percentage of Pennsylvanians at risk due to unhealthy behaviors.

Among the results:

- Smoking among adult Pennsylvanians is down three percent from 1989, the first year the department conducted the study.
- Forty-five percent of respondents were at increased risk of serious injury and death in the event of a car crash because they reported that they do not always use a seat belt when driving or riding in a car.
- Less than half of women aged 50 and older reported having had a mammogram and breast exam done

Got the "You-Know-It's-Cold-When-You're Curlin'-by-the-Fire-with-a-Copy-of-the-Clinton-Bill" Blues? . . . Uh-oh. It's been winter tooooo long!



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The Pennsylvania Medical Society 1994 Spring Assembly immediately following the 20th HMSS Assembly:

"Forming PHOs: Hospital and Physician Perspectives"

Tuesday, April 19
8:30 - 11:30 a.m.

by a health professional within the past year.

• Being overweight is a problem that plagues 28 percent of Pennsylvanians.

• Thirty-three percent of respondents reported having high blood pressure, 27 percent reported having high cholesterol, 20 percent reported having arthritis, and six percent reported having diabetes.

Questions also focused on other health risks (physical inactivity, HIV/AIDS, weapon carrying), health insurance coverage, and routine physician visits.

The survey is based on a random telephone study of 2,405 Pennsylvania adults and was conducted in cooperation with the Centers for Disease Control and Prevention, Atlanta. Data are compared to similar survey responses nationwide.

To request a copy of survey results, call DOH's Division of Health Promotion at (717) 787-5900.

AMA, USP EXPANDING PATIENT EDUCATION COLLABORATION

The American Medical Association (AMA) and the U.S. Pharmacopoeia (USP) have agreed to work together to develop a print- and computer-based patient education system that will enable physicians to provide patients with information about their drug therapy needs. This effort builds on the AMA's Patient Medication Instruction Sheet (PMI) program that was initiated with USP in 1981.

One of the most important goals of the expanded program, according to AMA and USP officials, is to encourage consistency in the content and delivery of information to patients from physicians and pharmacists, the two primary providers of USP patient education information. Reinforcement of information of similar content, format, and style can be a major contribution to increasing patient drug therapy compliance.

The current offering of preprinted AMA PMI for the approximately 100 most commonly used drugs or drug classes, which are based on the USP DI database, will continue to be available. As the first step in the program, the AMA and USP will develop a loose-leaf book of PMIs based on the complete standard USP DI leaflet database, which includes approximately 650 individual titles. Prescribers will be able to photocopy the information for patients as the drug is prescribed.

The second phase of the program will include development of companion loose-leaf books of Easy-to-Read and Spanish language leaflets. USP will also develop for the AMA a leaflet diskette for physicians' offices enabling them to print, rather than photocopy, information for their patients. When the joint program is fully implemented, the entire leaflet database will be available electronically for physicians to create patient-specific education leaflets.

For additional information about the PMI and expanded programs, call the AMA at (800) AMA-3211.

Society Goals Strengthened by Cooperative Efforts

The Pennsylvania Medical Society welcomes the opportunity to participate in organizations and coalitions whose goals are in line with those of the Society. Such participation often strengthens Society efforts through the cooperative support of others. While some groups with which we are aligned receive considerable attention in Society publications, others may go unnoticed. From a long list of Society alliances, the following are some less publicized:

• *Advance Directives Public Relations Task Force*—Develops public education materials for community education workshops on advance directives and durable power of attorney.

• *American Tort Reform Association*—Works to increase the awareness and need for reforming the general tort system, and serves as a clearinghouse for information on national tort reform activities; also focuses on medical liability reform.

• *Attorney General's Drug Abuse Task Force*—Develops strategies to fight drug abuse in Pennsylvania.

• *Dr. Martin Luther King Jr. Youth Assembly*—Promotes education of youth in principles of nonviolence.

• *Medical Group Management Association*—Works to enhance health care delivery and administration through a broad range of group practice leadership and professional development, education, credentialing, information, communication, advocacy, networking, and research activities.

• *PennCaire*—Addresses water and air quality issues.

• *Pennsylvania Association for Organ and Tissue Donation*—Promotes and facilitates the donation of organs and tissues through legislation, public awareness, and interdisciplinary approaches.

• *Pennsylvania Emergency Health Services Council*—Develops statewide standards for emergency medical services. The Society is a founding member.

• *Pennsylvania Society for Biomedical Research*—Promotes the safe use of animals in biomedical research.

• *Pennsylvania Trauma Systems Foundation*—Establishes standards for trauma centers in Pennsylvania and accredits those that meet those standards.

• *Stop AIDS Via Education (SAVE)*—Works to foster good AIDS education in the schools of Pennsylvania.

HOUSE OF DELEGATES NEWS

CALL TO 1994 ANNUAL MEETING

The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Hershey Lodge and Convention Center, Hershey, Pennsylvania, on Friday, October 21, 1994. The second session will convene Saturday, October 22, 1994, and the third session Sunday, October 23, 1994. Details regarding the starting times of all three sessions will appear in the "Official Call" in the August 1994 issue of PENNSYLVANIA MEDICINE.

All proposed amendments to the bylaws must be submitted to the office of the secretary of this Society on or before June 21, 1994. Such amendments may be proposed upon the written petition of 15 active or associate members of the Society, or by the Committee on Bylaws.

Resolutions to be considered by the House may be submitted in writing to the secretary by a delegate acting in his or her own behalf or for the component medical society or specialty society he or she represents. If received prior to September 21, 1994, resolutions will be published in the *Official Reports Book.*

The Society's Educational and Scientific Trust has announced the establishment of the **Raymond C. Grandon, MD,** and Doris N. Grandon Fund and the **Martin A. Murcek, MD,** Fund. Both funds—established with gifts from "three presidents in medicine's family"—will assist in underwriting expenses for physician leadership development offered by The Institute for Physician Leadership of the Trust.

Dr. Malcolm

John A. Malcolm Jr., MD, Sunbury, on behalf of the State Society, attended the inaugural meeting in January of the National Quality Summit. The mission of the summit is "to foster a system of enhanced accountability for the quality of health care provided under health system reform through coordination of public and private sector efforts to evaluate and enhance quality." The meeting was hosted by the AMA.

Two Hahnemann University School of Medicine students were among 25 medical students nationwide to receive 1994 AMA/Glaxo Achievement Awards for demonstrating strong, non-clinical skills. **Rebecca L. Kunkel,** past State Society medical student trustee, was recognized for her active participation in organized medicine, and **Edward Kantor** was recognized for his commitment to promoting community involvement as an integral part of the medical school curriculum. Each received a $900 stipend to assist with travel and accommodations to attend the AMA National Leadership Conference in February.

Ratmir R. Ciganic, MD, Wexford, has been appointed chief of radiology, Suburban General Hospital, Pittsburgh.

Asher Woldow, MD, chief of cardiology and president of the medical staff, Philadelphia Geriatric Center, has been named clinical professor of medicine, Temple University School of Medicine, Philadelphia.

Saul Jeck, DO, has been named chief of staff, Graduate Health System, City Avenue Hospital, Philadelphia.

David S.C. Pao, MD, has been promoted to associate surgeon, Cataract and Primary Eye Care Service, Wills Eye Hospital, Philadelphia.

The Berks County Medical Society (BCMS) installed the following officers at its installation dinner held in Reading in January: Rocco F. Chirieleison, MD, president; John C. Moser, MD, president elect; and William J. West Jr., MD, secretary. Also at the dinner, Richard T. Bell, MD, a BCMS past president, received the county society's 1994 Community Service Award in recognition of his community volunteer activities. Pictured above: Dr. Chirieleison (left) presents Dr. Bell (right) with the BCMS Community Service Award.

Dr. McHugh

James E. McHugh, DO, vice president of medical affairs, Suburban General Hospital, Norristown, has been appointed to the National Board of Osteopathic Medical Examiners (NBOME).

Chestnut Hill Hospital, Philadelphia, installed the following officers for 1994: **Ramsey Thorp, MD,** president; **Baxter Holland, MD,** vice president; and **Nancy Gettes, MD,** treasurer/secretary. Also at the hospital, **Marc W. McKenna, MD,** has been appointed director of the family practice residency program and family practice unit.

The Lupus Foundation of Philadelphia presented Sheryl N. Hirsch Research Grants to **Michael P. Madaio, MD,** associate division chief, Renal Electrolyte and Hypertension Division, and **Leslie E. Silberstein, MD,** director, Blood Bank and Transfusion Medicine Section, University of Pennsylvania Medical Center, Philadelphia.

Myles Turtz, MD, Cherry Hill, New Jersey, has been appointed executive vice president of Allegheny Health, Education and Research Foundation for Systems Development. His responsibilities include working with the CEOs of five Delaware Valley hospitals.

The *New England Journal of Medicine* published an article authored by **John Ditunno Jr., MD,** Thomas Jefferson Medical College of Thomas Jefferson University, Philadelphia, and **Christopher Formal, MD,** Magee Rehabilitation Hospital, Philadelphia. The article reviews facts and figures about spinal cord injury.

Lawrence J. Schneiderman, MD, San Diego, California, has been named the 1994 Medical College of Pennsylvania (Philadelphia) Katharine Boucot Sturgis Visiting Professor in the Department of Community and Preventative Medicine.

Chestnut Hill Hospital, Philadelphia, has appointed **Jonathan Rogers, MD,** Lower Gwynedd, chief of orthopedics.

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National Cooperative Projects Are New PRO Direction: HCQIP

Donald E. Harrop, MD

In this fourth of a series of articles on the new peer review organization Health Care Quality Improvement Program, KePRO's president overviews national cooperative projects.

You may notice that in the above title, HCQIP has replaced the HCQII of the previous three articles. The Health Care Financing Administration (HCFA) has decided that the Health Care Quality Improvement Initiative is no longer an initiative, but is now a full-fledged "program." This is just one of the many changes expected as peer review organizations (PROs) move farther into this new direction, and both the PROs and HCFA gain more experience with data analysis and information feedback.

Although HCFA has not yet determined any minimum number of local cooperative projects, PROs are expected to have a variety of projects in progress and in various stages of development at any given time, with some consideration given to the size of the PRO. National cooperative projects are handled somewhat differently, however, since they may be difficult to initiate and coordinate. HCFA determined the subject for the first two national cooperative projects, and this is expected to continue, although I'm sure PROs will have the opportunity to make suggestions.

The first national project is referred to as the Medicare Hospital Information Project (MHIP) and involves annual mortality data HCFA has publicly released each of the last several years. This year, rather than releasing the data to the media as in the past, each hospital will receive only its own data along with some statewide and national figures for comparison purposes, and the factors used to predict the mortality rates.

Each PRO will receive data applicable to its state, and is expected to analyze the data for regional and provider-specific variations. Focused medical review, explained in this column in January, will be instituted when a significant variation is identified; that is, the information learned from the analysis will be communicated with the individual provider(s).

Further study, with provider cooperation, is then conducted to determine if the variation truly represents a problem with the treatment process. If so, the information learned from the study is communicated to the provider(s) to help them to provide more effective treatment.

Our initial analysis of the 1993 Hospital Report, which utilizes 1991 data, did not identify any dramatic variations in the Pennsylvania hospital data. We are communicating our findings to hospital chief executive officers and using the data as an adjunct to other analyses. HCFA expects that these analyses will be used as a tool in other patterns and outcomes analyses. The MHIP will most likely continue to be an annual PRO project.

Most national projects will probably be conducted in the same or similar manner as the cooperative cardiovascular project (CCP), the other current national project. In this case, four PROs (not including KePRO) were selected to participate and conduct the study on a pilot basis. The intent is to assess the processes and outcomes of care for patients hospitalized for acute myocardial infarction (AMI), coronary artery bypass grafting (CABG), and percutaneous transluminal coronary angioplasty (PTCA).

These PROs will develop statistical quality assurance methodologies, generate feedback techniques, and develop cooperative techniques for improving processes and outcomes of care. We expect that all remaining PROs will participate in this study after the entire methodology has been refined.

Although the HCQIP process is quite complicated and involves numerous steps in the development of both local and national projects, we at KePRO are determined to not lose sight of our mission as a PRO. We fully intend to continue to strive to assure that Medicare beneficiaries receive quality of care, efficiently delivered. ⬡

Dr. Harrop is president of the Keystone Peer Review Organization.

ANNUAL 1993 REPORT

THE EDUCATIONAL AND SCIENTIFIC TRUST
A Legacy To Medicine

From the Executive Director

IN MAY 1994, I WILL RETIRE AFTER 22 YEARS OF SERVICE AT THE Pennsylvania Medical Society and 12 years as executive director of The Educational and Scientific Trust. During my tenure, the Trust has grown in ways I never thought possible. When I came in 1982, the Trust had a staff of two, assets of $3 million, an annual budget of $80,000, and one focus — the student loan program. Today, the Trust has a staff of 17, assets of $8 million, an annual budget of $1.5 million, and seven major areas of focus.

Our growth can largely be attributed to the continuous support of Pennsylvania physicians, the Pennsylvania Medical Society and Alliance, the county medical societies and alliances, and other friends. I believe you, in partnership with the Trust, are making a difference here in the Commonwealth.

The Trust has expanded significantly within the realms of financial possibility. Our *student loan program* provides between $300,000 and $500,000 annually to students in need. The *Physicians' Health Programs* has an active case load of 450 physicians and has helped over 1,000 individuals on their way to recovery. *The Institute for Physician Leadership* is working diligently to enhance the human relations and organizational skills of medical leaders so they can successfully direct their institutions and professional organizations. One of our newest programs is *Keystones of Public Health*, a coalition focusing on education and information dissemination relating to Pennsylvania's public health priorities. *Keystones* takes the Trust back to its 1954 roots of addressing public health needs.

The Trust has reached the point of expansion where we must now pause and assess our progress. At our 1993 board planning retreat, the Trustees directed us to make each of our programs financially stable. Raising funds to sustain our programs remains a priority, and we continue to rely on your support. As we do, we promise to remain faithful stewards of your generosity.

I'm excited about the future of the Trust. The board has selected Matthew J. Tornambe as my successor. Mr. Tornambe has served for the past 10 years as the executive director of the Central Pennsylvania Chapter of the National Multiple Sclerosis Society. His experience in non-profit management and fund-raising will enable the Trust to continue serving the physicians of Pennsylvania. As the leadership of the Trust changes, the growth of programs and interpretation of priorities will also change. But the Trust remains committed to serving the needs of medicine.

To those who have watched the Trust grow over the years and to those who are newer friends, I extend my personal gratitude for your commitment and support of the Trust.

I used to buy apples and peaches at an orchard outside of Bowmansdale, Pennsylvania. As I paid for my fruit, my farmer friend always said to me, in a most sincere way, "Thanks a whole lot." That is how I feel about my years of association with you, and I express it in a most sincere way, "Thanks a whole lot."

LeRoy C. Erickson

1993

From the Chairman

You have before you the thirty-ninth annual report of The Educational and Scientific Trust. For 39 years, the Trust has provided programs and services which benefit Pennsylvania physicians and the public.

You are an important part of our growth and progress. Your dedication and support of the Trust's programs have enabled us to expand. The effectiveness of our retiring executive director has been another crucial element of the Trust's progress. His leadership has guided the Trust through some turbulent times to a position of stability and sustained growth.

On behalf of the Board of Trustees and staff, I extend a special note of thanks to LeRoy C. Erickson and wish him the best in his future endeavors. The Trust looks forward to new opportunities with our incoming executive director, Matthew J. Tornambe. I am confident in his ability to lead the Trust into the future.

The Trust was initially established to address public health needs on behalf of Pennsylvania physicians. While we have maintained that priority, we have also expanded into several other areas. Our annual report highlights the following activities: the loan programs, projects, the Physicians' Health Programs, The Institute for Physician Leadership, Keystones of Public Health, fund-raising, and finance.

Abram M. Hostetter, MD
Chairman, Board of Trustees

Loan Programs

Student Loans

The Trust's most long-standing activity is its student loan program. The loan program has provided $9.8 million in financial assistance to more than 3,200 medical and allied health students.

The basic loan for medical students is $3,000 and $1,500 for allied health students. For the 1993-94 school year, the Trust granted $334,988 to 117 medical students and $43,300 to 33 allied health students.

Pennsylvania Medical Society members have been the mainstay of the medical student loan program over the years. Ten dollars from each member's dues is allocated to the Trust's Medical Student (Educational) Fund. Throughout the years, members have provided $3.2 million through these dues allocations.

Members were given the option on their 1993 dues statement to make an additional $10 contribution to the medical student loan fund. Almost 4,000 members responded with a gift of $10 or more.

The dedication of Society members and other friends of medicine demonstrates the Trust's continuing legacy to the future of Pennsylvania medicine and physicians-in-training. The Trust remains committed to providing financial assistance to students in need.

Residency Relocation Loans

In 1991, the Trust established the Residency Relocation Loan, which provides additional financial assistance to our loan borrowers once they have completed medical school. Every borrower preparing to enter a residency program is eligible to receive up to $1,000 to help with relocation and living expenses. The Trust distributed $46,000 to eligible borrowers in 1993 and has granted $116,900 since the program began.

Loans for Children of Deceased or Disabled Physicians

The Trust administers a special loan program to help unmarried, dependent children of deceased or disabled Pennsylvania Medical Society members complete their education if the family's financial resources are not adequate to do so. This loan is available to any eligible student enrolled in a high school, college, or graduate school located in

the United States. The loan is interest-free while the student is in school. In 1993, the Trust distributed $12,000 to four eligible students. Over the years, the Trust has granted a total of $229,648 to 92 students.

Pennsylvania Medical Society Student Memberships

Since 1988, the Trust has offered to pay Pennsylvania Medical Society student memberships for interested Trust loan recipients. The Trust hopes to acquaint borrowers with the benefits of organized medicine while they are still in school. In 1993, the Trust paid memberships for 39 students.

Financial Aid Officers' Workshop

This year, the Trust sponsored its twentieth annual financial aid officers' workshop. Representatives from Pennsylvania medical schools, the Pennsylvania Higher Education Assistance Agency (PHEAA), and the U.S. Department of Health and Human Services attended to discuss the present issues facing financial aid programs. The workshop allowed the schools' officers to network with other financial aid organizations at the state and federal level.

Each spring, the American Medical Association Education and Research Foundation (AMA-ERF) presents each Pennsylvania medical school with cash awards to benefit the school's programs. The funds are primarily generated by county medical society alliances. Sue Pan, 1993 president of the Pennsylvania Medical Society Alliance, and Roger Mecum, executive vice president of the Pennsylvania Medical Society, awarded checks totaling over $65,000.

Special Thanks

The Trust would like to thank the Pfahler Foundation, administered by the Philadelphia County Medical Society, for its contribution of an outstanding student loan portfolio valued at $137,550. We have collected $135,463 in principal and interest and are pleased to report that only two loans remain outstanding. Over the years, this money has been added to the Medical Student (Educational) Fund to support new student loans.

Projects

The Trust uses a marketing philosophy as the basis for conducting many of its projects and programs. We use research to determine an audience's needs and then develop recommendations or materials to meet those needs. In 1993, the Trust supported the Pennsylvania Medical Society's endeavors and addressed relevant health care issues in this manner.

Elder Abuse and Protective Services. Under contract with the Pennsylvania Department of Aging, the Trust produced a third professional training videotape on recognizing and reporting cases of suspected elder abuse. The Trust has now produced training videotapes for home health nurses, emergency personnel, and law enforcement officials.

Group Practice Study. The Pennsylvania Medical Society contracted with the Trust to conduct a study exploring ways the Society can satisfy the needs and desires of group practices and physicians in those practices. The Trust conducted focus groups with physicians in group practices, interviews with group practice administrators, and a written survey of administrators.

Mature Drivers' Task Force. Since 1992, the Trust has administered the Mature Drivers' Task Force which educates older adult drivers on their special needs. Highlights of the task force's 1993 activities include distribution of a video on mature driving, a project to teach grandparents how to safely transport grandchildren, and the promotion of driver refresher courses in license renewal mailings.

1993

Medical Student Health Insurance Study. At the request of the Pennsylvania Medical Society, the Trust designed and distributed a questionnaire on the health insurance needs of Pennsylvania medical students. A random sample of students across the state received the survey.

Pennsylvania Academy of Family Physicians (PAFP) Organizational Study. The Trust utilized its marketing capabilities to assist the PAFP in assessing its organizational structure and its ability to best serve members. The Trust developed a questionnaire for PAFP members, which solicited their opinions on various aspects of the PAFP. As follow-up, the Trust will make recommendations on how the PAFP can better serve its membership.

Pennsylvania Medical Society Leadership Conference. The Trust again provided program development support for the Society's annual Leadership Conference.

Physician Referral Network. The Trust continued to provide administrative support to the Pennsylvania Medical Society's efforts to establish a statewide Physician Referral Network (PRN). The PRN was established to: improve access to essential health care services for Medical Assistance and uninsured patients; coordinate the referral of patients from one health care professional to another; and document the need for and use of medical services by the poor and medically indigent.

Task Force to Enhance Physician Involvement Study. The Trust staff conducted focus groups for the Society's Task Force to Enhance Physician Involvement to discover reasons why more physicians are not involved in Society activities. Trust staff presented the study results to the Pennsylvania Medical Society Board of Trustees.

Visitor's Day. Over the years, the Trust has received inquiries from several state medical societies about establishing their own charitable organizations. In response, the Trust set aside a day for interested parties to visit the Trust and learn more about our activities. Representatives from Virginia, Texas, and Michigan attended the visitor's day in September.

Keystones of Public Health

In an effort to return to its roots, the Trust established Keystones of Public Health in 1992. Keystones is a coalition focused on education and information dissemination relating to Pennsylvania's public health priorities. The Trust has been investigating the best way to become involved in the public health arena and, as a result, has been conducting several different activities.

During 1993, Trust staff wrote a series of articles focusing on physicians involved in public health which were published monthly in PENNSYLVANIA MEDICINE. The articles provided resources for physicians interested in more information. During 1993, topics included diabetes management, child abuse, nicotine addiction, health and fitness, migrant health care, and the need for local health departments.

In November, Keystones kicked off the first of many efforts to bring public health professionals together. Keystones sponsored a marketing seminar for Pennsylvania public health professionals. Over 50 individuals attended and gave the seminar a positive review.

For Keystones to be effective, the Trust feels it is crucial to bring together representatives from the medical and public health communities, as well the private and public sectors. In December, Keystones invited representatives of these communities to the initial meeting of Keystones' steering committee. The committee discussed issues facing the Keystone initiative and future directions for the coalition.

1993

Physicians' Health Programs

About the PHP

Since 1989, the Physicians' Health Programs (PHP) has been a thriving component of the Trust's services. The PHP offers advocacy and support to physicians experiencing impairment from physical, emotional, or mental conditions. Drug and/or alcohol addiction is the primary cause of impairment with which the PHP deals.

A physician certified in addiction medicine leads the PHP's experienced staff. The staff of four works diligently to assist physicians, hospitals, colleagues, and family members with impairment issues.

The PHP has helped 1,073 physicians through the recovery process. The PHP's active case load is 472. While most PHP participants refer themselves to the program, other referral sources include hospitals, colleagues, and the State Board of Medicine. Anyone can refer a physician to the PHP. The program treats each referral with complete confidentiality.

When someone contacts the PHP about a physician, the PHP collects appropriate background information and assists in intervening with the physician. Impaired individuals are encouraged to enroll in the program. Upon enrollment, the physician must agree to enter a course of treatment deemed appropriate by the medical director. This includes active participation in a treatment program, attendance at support programs, and monitoring by the PHP for three to five years. The PHP sets the course of action based on each individual's needs.

The PHP's services are available to any Pennsylvania physician, medical practice, or hospital.

1993 Activities

The PHP's primary activities are intervention and monitoring of physicians, but the PHP is active in other areas as well. Outreach to medical students is becoming an increasing priority for the PHP. In 1993, the PHP staff made presentations to medical students at Hahnemann University, Pennsylvania State University, Temple University, the University of Pennsylvania, and the University of Pittsburgh. It also published a brochure targeted to medical students about impairment and PHP services. This outreach teaches medical students that physicians are not immune to drug and alcohol addiction, enables them to recognize the signs of impairment, and lets them know PHP services are available to them.

Hospital outreach is another important element of the PHP. The PHP is available to make presentations on impairment or to help hospitals establish their own internal committee or policy to deal with impairment issues. The PHP developed a booklet on this topic, which is available to any interested organization. In 1993, the PHP made presentations to 14 hospitals statewide and is formulating a comprehensive plan to ensure broader outreach to hospitals.

The PHP also published two newsletters for hospitals who have supported the program financially. The **PHP Update** is distributed to all contributing hospitals. The **Key Supporter Special** is sent to contributing hospitals which have reached the Key Supporter giving level ($10 per medical staff member). In 1993, the newsletters covered stress management, recognizing the chemically dependent physician, and graduated re-entry to practice. The PHP also placed bimonthly advertisements in PENNSYLVANIA MEDICINE, offering its services to physicians.

In addition to hospital outreach, PHP staff spoke to physicians from three county medical societies in 1993: Monroe, Allegheny, and Dauphin. The county medical societies provide a good outlet for informing physicians of the availability of PHP services. PHP representatives also participated in conferences sponsored by other related organizations, such as the American Medical Association, the American Academy of Psychiatrists, and the American Psychiatric Association.

In April, the PHP Committee and staff held a retreat to evaluate the program's current status and progress. They decided to continue working closely with the State Board of Medicine, but not accept financial

Physicians' Health Programs

continued

support from it. They also committed to increasing efforts to garner financial support from Pennsylvania hospitals.

Additionally, the PHP conducted personal interviews with Pennsylvania Medical Society leaders and distributed a written survey to all attendees at the annual House of Delegates meeting. The research results indicated that the leaders want more information about the PHP and recognizing physician impairment. The staff continues to evaluate the program and assess ways to improve services to physicians.

Financial Assistance

In 1989, the PHP established a Re-Entry of Practice Loan program. The program enables PHP participants to receive up to $1,000 a month for one year for living expenses while they find employment or re-establish practice. Since the program began, the PHP has loaned over $98,000 to 12 recovering physicians.

Because of financial concerns, the PHP Committee and Trust Board have decided not to continue offering the program in the future.

Financial Support

In 1993, the PHP received $286,000 in generous contributions from hospitals, individuals, and related organizations. The sustained support of these parties enables the PHP to continue providing important services to the Commonwealth's physicians and hospitals.

The PHP extends special thanks to the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) for its generous annual commitment to the program. Since 1987, PMSLIC has provided an annual grant to underwrite the program.

To contact the PHP

The PHP can be reached at (800) 228-7823 between 8 a.m. and 4 p.m. Monday through Friday. At all other times, you may leave a confidential message by calling (717) 558-7817.

Mission Statement

The mission of the Physicians' Health Programs (PHP) is to assist physicians and physicians-in-training to understand, accept, and cope with the physical, emotional, spiritual, and mental conditions which impair or threaten to impair their health and well-being, and thus help the physicians to meet the usual and acceptable standards of medical care required of licensed physicians in the Commonwealth of Pennsylvania. In doing so, the program shall act to promote the health and attitudes of physicians, and thus the safety and welfare of the public.

In order to be successful in its mission, the PHP will assist the family of the impaired physician through support, guidance, education, and encouragement in order to enhance their well being.

Consultation, education, and support shall be provided to both the physician and his/her family under the stress of professional liability litigation.

The Institute for Physician Leadership

In 1990, the Trust established The Institute for Physician Leadership to train physicians to be effective leaders of their institutions and professional organizations. The Institute takes physicians out of their clinical paradigm and works to augment their human relations and organizational skills. The Institute shows medical leaders new approaches to:

- Communicating one-on-one and in small groups;
- Drawing positive results from conflict;
- Using active listening skills to communicate;
- Motivating peer participation;
- Running more efficient meetings;

- Injecting team concepts into committees; and
- Negotiating.

In addition to working with physician leaders, the Institute uses its resources to assist the staffs of county medical societies and other related organizations to serve their audiences more effectively.

More than 1,200 individuals have participated in an Institute activity in the last three years. In 1993 alone, over 600 physicians and staff members attended a program.

Sponsorship

During its three years of pilot operation, the Institute was underwritten by The Educational and Scientific Trust, the Pennsylvania Medical Society, and Jefferson Medical College . The Institute extends special thanks to Jefferson for its three-year commitment to the program. Institute expenses are offset by workshop fees.

Additionally, the Upjohn Company gave a generous grant to cover the expense of the town meeting at the Pennsylvania Medical Society Leadership Conference.

Leadership Resources Available

The Institute publishes a biannual newsletter entitled **Leadership Digest**. The digest provides recipients with current case studies and information on different components of effective leadership. 1993 topics included maximizing employee potential, listening, total quality management, communications skills, and stress management.

In addition to the digest, the Institute has resources on other pertinent topics including listening, negotiating, team-building, meeting administration, presentations, conflict resolution, and leadership.

Mission Statement

The Institute's mission is enhancing the influence of physicians in the health care system so that quality may be preserved.

The Institute for Physician Leadership

THE INSTITUTE FOR PHYSICIAN LEADERSHIP

Administrative Services

One of the important ways the Trust supports organized medicine is by providing administrative services to related organizations. In 1993, the Trust provided financial services to 17 groups and newsletter writing, editing, and desktop publishing services to six.

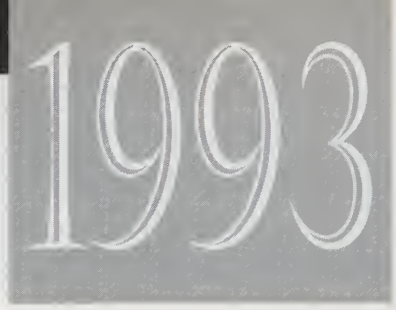
Public Relations

The Trust undertook several public relations activities during 1993. We continued publishing our quarterly newsletter, **Connections**. Circulation now includes over 7,000 individuals and organizations. The newsletter serves as the primary vehicle to disseminate timely activity updates to our contributors, loan borrowers, related organizations, and other friends.

The Trust showed a videotape about the Trust's activities to the boards of the Pennsylvania Medical Society, the Pennsylvania Medical Society Liability Insurance Company, and the Keystone Peer Review Organization. The intent was to educate the leadership of our related organizations about the Trust's many endeavors.

The Trust and the PHP ran monthly advertisements in PENNSYLVANIA MEDICINE and distributed copies of the advertisements to county medical society bulletin editors. Ten county medical societies published advertisements on behalf of the Trust.

The PHP distributed an educational videotape about the program to all hospitals who contributed in 1993. The videotape conveys details about the program's services and the assistance offered.



Financial Statements

THE EDUCATIONAL AND SCIENTIFIC TRUST
Balance Sheet at December 31,1993

	Current		Funds Specified for					1993	1992
	Unrestricted Funds	Restricted Funds	Student Loan Programs	Physicians' Health Programs	Medical Benevolence	Physician Leadership	Endowed Funds	Total All Funds	Total All Funds
ASSETS:									
Cash	(240,614)	73,334	156,588	(71,846)	(3,688)	4,559	55,276	(26,391)	45,223
Investments at lower cost and market	17,376	141,069	178,517	3,136	1,583,428	16,377	172,123	2,112,026	566,141
Loans receivable	0	16,460	5,362,915	80,697	0	0	0	5,460,072	5,510,377
Accrued student loan interest	0	0	129,015	0	0	0	0	129,015	139,191
Accounts receivable	25,963	15,355	24,738	19,783	0	0	3,000	88,839	84,020
Office equipment, net accumulated depreciation	77,223	0	0	14,425	0	0	0	91,648	65,558
Intangible pension asset	178,249	0	0	0	0	0	0	178,249	178,249
Prepaid pension costs	28,594	0	0	0	0	0	0	28,594	28,594
Prepaid expenses	4,052	0	0	928	0	0	0	4,980	7,228
TOTAL, ASSETS	*90,843*	*246,218*	*5,851,773*	*47,123*	*1,579,740*	*20,936*	*230,399*	*8,067,032*	*6,624,581*
LIABILITIES AND FUND BALANCE:									
Accounts payable	10,408	0	0	1,570	0	0	0	11,978	53,763
Accrued taxes	197	0	0	0	0	0	0	197	422
Accrued pension liability	178,249	0	0	0	0	0	0	178,249	178,249
Unearned revenue	0	0	1,007	0	0	0	0	1,007	134,980
Total Liabilities	**188,854**	**0**	**1,007**	**1,570**	**0**	**0**	**0**	**191,431**	**367,414**
Total, Fund Balance	**(98,011)**	**246,218**	**5,850,766**	**45,553**	**1,579,740**	**20,936**	**230,399**	**7,875,601**	**6,257,167**
TOTAL, LIABILITIES AND FUND BALANCE	*90,843*	*246,218*	*5,851,773*	*47,123*	*1,579,740*	*20,936*	*230,399*	*8,067,032*	*6,624,581*

Note 1: The financial statements shown in this report are unaudited. Audited statements are being prepared and will be available upon request in April.

Note 2: Current unrestricted funds are those funds used to maintain normal operations of the Trust (including projects and programs) and do not require prior approval for their use. Current restricted funds are funds held in reserve by the Trust not designated for a specific purpose, but cannot be used without the permission of the Board of Trustees (or others for whom the fund is maintained). Endowment funds are gifts to the Trust to use revenue generated from that gift for a specific purpose.

Note 3: Investments are recorded at cost. In 1993, market value is $2,392,051; in 1992, market value is $660,552.

Note 4: Prior Period Adjustments: Adjustments reflect school and residency loan interest accruals to report interest in proper year, and the transfer of the Medical Benevolence Fund from the Pennsylvania Medical Society to the Trust in 1993.

Note 5: Interfund Transfers: Interfund transfers are transfers of funds within the Trust, having no net effect on the fund balance of the organization. However, these transfers must be noted on the financial statements.

1993

THE EDUCATIONAL AND SCIENTIFIC TRUST
Schedule of Revenue, Expense, and Changes in Fund Balance
for the year ending December 31, 1993

	Current		Funds Specified for						
	Unrestricted Funds	Restricted Funds	Student Loan Programs	Physicians' Health Programs	Medical Benevolence	Physician Leadership	Endowed Funds	1993 Total All Funds	1992 Total All Funds
REVENUE:									
Administrative grants/Dues allocations	69,240	0	135,964	234,800	0	26,000	0	466,004	329,200
Contributions	6,421	48,192	126,543	89,908	0	1,669	60,781	333,514	369,186
Revenue from outstanding loans	318,556	0	0	2,982	0	0	0	321,538	352,794
Investment revenue	54	3,478	5,824	914	6,556	396	3,117	20,339	19,814
Net gains on investments	1,280	11,517	9,555	4,687	14,620	862	7,809	50,330	34,596
Projects and programs	106,827	0	0	29,252	0	0	0	136,079	126,155
Administrative services	29,883	0	0	7,117	0	0	0	37,000	53,907
Workshops and seminars	5,635	12,020	0	0	0	0	0	17,655	16,784
Miscellaneous	708	0	961	0	231	0	0	1,900	4,196
Total Revenue	**583,604**	**75,207**	**278,847**	**369,660**	**21,407**	**28,927**	**71,707**	**1,384,359**	**1,306,632**
EXPENSES:									
Salaries and benefits	463,630	0	64,372	372,583	2,057	26,991	0	929,633	858,739
Travel and meetings	32,228	14,016	885	25,352	0	3,138	0	75,619	45,643
Advertising and publications	20,769	0	2,026	4,837	0	2,494	0	30,126	28,827
Delinquent and uncollectible loans	0	0	31,505	0	0	0	0	31,505	5,318
Grants and scholarships	0	4,525	0	0	12,140	0	200	16,865	0
Consulting	39,626	136	18,751	25,023	1,481	2,562	0	87,579	72,749
General and administrative	75,123	687	10,124	56,109	150	5,160	0	147,353	162,995
Projects and programs	4,700	20,000	0	14,835	0	0	0	39,535	124,204
Miscellaneous	1,052	0	1,433	833	0	40	0	3,358	20,456
Total Expenses	**637,128**	**39,364**	**129,096**	**499,572**	**15,828**	**40,385**	**200**	**1,361,573**	**1,318,931**
REVENUE OVER/(UNDER) EXPENSES	**(98,524)**	**35,843**	**149,751**	**(129,912)**	**5,579**	**(11,458)**	**71,507**	**22,786**	**(12,299)**
FUND BALANCE, January 1	(26,773)	228,655	5,705,732	170,097	0	17,394	162,062	6,257,167	6,166,558
PRIOR PERIOD ADJUSTMENT	21,487	0	0	0	1,574,161	0	0	1,595,648	102,908
INTERFUND TRANSFERS	5,799	(18,280)	(4,717)	5,368	0	15,000	(3,170)	0	0
FUND BALANCE, December 31	***(98,011)***	***246,218***	***5,850,766***	***45,553***	***1,579,740***	***20,936***	***230,399***	***7,875,601***	***6,257,167***

Development

The Trust has experienced tremendous growth over the last decade. This growth can be largely attributed to the continued dedication of our generous supporters. Raising funds to support Trust programs remains a priority. As we continue to expand, we are exploring new avenues of funding.

At its 1993 planning retreat, the Board requested the formation of a long-range development plan. The plan includes all major programs of the Trust and coordinates solicitation appeals. The Trust will begin implementing the master plan in mid-1994.

The Trust's planned giving program continued to grow during 1993. We were notified of three planned gifts throughout the year. To promote this way of contributing, the Trust placed articles and advertisements in PENNSYLVANIA MEDICINE, and staff conducted workshops at several Pennsylvania Medical Society Alliance functions. To comply with the Commonwealth's legal requirements, the Trust established a separate corporation, the Medical Legacy Fund, to accept and manage planned gifts.

In 1993, 5,140 physicians and other friends of the Trust contributed $226,467. In

1993

Development
continued

addition to an administrative grant, the Pennsylvania Medical Society offered its members the opportunity to make a $10 contribution on their 1993 dues statement. Almost 4,000 members took advantage of this opportunity and gave $39,950.

More than 100 individuals, hospitals, and other related organizations gave $91,293 in support of the Physicians' Health Programs. Additionally, the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) provided a generous administrative grant to help underwrite the costs of the program.

Contributor Recognition

The Trust is pleased to recognize those physicians, hospitals, related organizations, and other friends whose support continues to ensure our success. Their giving demonstrates their commitment to The Educational and Scientific Trust and the future of medicine. The Trustees and staff extend our sincere gratitude and are pleased to recognize our 1993 contributors.

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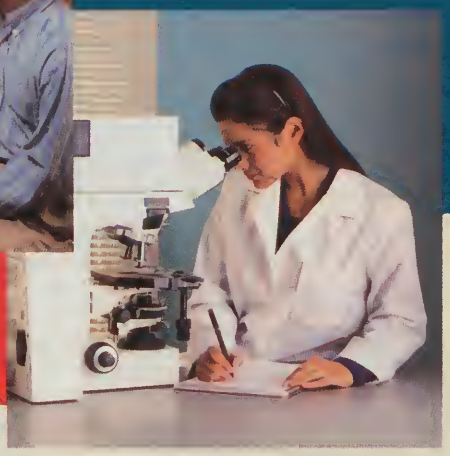

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OBITUARIES

David C. Bennighof, MD, *Sharptown, MD*
Johns Hopkins University School of Medicine, 1951; age 67, died January 26, 1994.•

Morris W. Brody, MD, *Bala Cynwyd*
Temple University School of Medicine, 1933; age 86, died January 29, 1994. Dr. Brody was a psychoanalyst.•

Elizabeth B. Brown, MD, *Wallingford*
Hahnemann University School of Medicine, 1945; age 85, died February 11, 1994. Dr. Brown was an allergist.•

Arthur M. Benshoff, MD, *Windber*
Jefferson Medical College of Thomas Jefferson University, 1915; age 102, died January 28, 1994. Dr. Benshoff was a general practitoner.•

Edward B. Charney, MD, *Cherry Hill, NJ*
New York University School of Medicine, 1971; age 48, died February 6, 1994. Dr. Charney was a pediatrician.•

Charles A. Horan, MD, *Berwyn*
Temple University School of Medicine, 1932; age 86, died February 7, 1994. Dr. Horan specialized in cardiovascular diseases.•

Nelson M. Kennedy, MD, *Darlington*
Temple University School of Medicine, 1954; age 76, died February 8, 1994. Dr. Kennedy was a general practitioner.•

Mieczyslaw S. Lopusniak, MD, *Merion Station*
Age 77, died January 28, 1994. Dr. Lopusniak was a gastroenterologist.•

Charles C. MacKinney, MD, *West Chester*
Age 74, died January 22, 1994. Dr. MacKinney was a urologist.•

Anthony T. Merski, MD, *Erie*
Marquette University School of Medicine, 1937; age 83, died January 24, 1994. Dr. Merski was a family practitioner.•

C. Joseph Miller, MD, *Jenkintown*
Jefferson Medical College of Thomas Jefferson University, 1934; age 84, died February 5, 1994. Dr. Miller was a gastroenterologist.•

Morton H. Spinner, MD, *East Stroudsburg*
St. Louis University School of Medicine, 1937; age 81, died February 5, 1994. Dr. Spinner specialized in occupational medicine.•

John M. Wagner, MD, *Clarks Summit*
Temple University School of Medicine, 1934; age 85, died January 24, 1994. Dr. Wagner was an internist.•

Gary G. Winzelberg, MD, *Gibsonia*
University of Massachusetts Medical School, 1974; age 45, died December 6, 1993. Dr. Winzelberg specialized in nuclear radiology.•

Aldolph F. Borkowski, MD, *Jenkintown*
Boston University School of Medicine, 1948; age 79, died January 3, 1994. Dr. Borkowski was an internist.

Stephen J. Brozena, MD, *Tampa FL*
Temple University School of Medicine, 1984; age 35, died December 12, 1993. Dr. Brozena was a dermatologist.

Robert J. Derham, MD, *Holland*
Jefferson Medical College of Thomas Jefferson University, 1944; age 74, died December 20, 1993. Dr. Derham specialized in occupational medicine.

William T. Ellis, MD, *Chambersburg*
Temple University School of Medicine, 1949; age 71, died December 22, 1993. Dr. Ellis was a family practitioner.

Alfred W. Eye, MD, *Spring Mills*
Hahnemann University School of Medicine, 1930; age 90, died October 29, 1993. Dr. Eye was an internist.

Gerhard H. Fromm, MD, *Pittsburgh*
Jefferson Medical College of Thomas Jefferson University, 1953; died January 6, 1994. Dr. Fromm was a neurologist.

Arthur F. Glah, DO, *Lancaster*
Philadelphia College of Osteopathic Medicine, 1966; age 64, died December 15, 1993. Dr. Glah was a general practitioner.

Carl L. Hosier, MD, *Scranton*
Hahnemann University School of Medicine, 1921; age 98, died December 8, 1993. Dr. Hosier was a radiologist.

Zoltan Z. Kish, MD, *Indiana*
Age 53, died December 13, 1994. Dr. Kish specialized in emergency medicine.

Henry D. Lederer, MD, *Coatesville*
Rush Medical College of Rush University, Illinois, 1937; age 79, died January 6, 1994. Dr. Lederer was a psychiatrist.

Robert Ledis, MD, *Philadelphia*
Hahnemann University School of Medicine, 1950; age 72, died November 25, 1993. Dr. Ledis specialized in occupational medicine.

John P. Lim, MD, *Stroudsburg*
Jefferson Medical College of Thomas Jefferson University, 1934; died December 13, 1993. Dr. Lim was a general practitioner.

Ernest L. Markey, DO, *York*
Philadelphia College of Osteopathic Medicine, 1934; age 84, died December 29, 1993. Dr. Markey was an anesthesiologist.

Edward S. Stafford, MD, *Chambersburg*
The Johns Hopkins University School of Medicine, 1931; age 87, died November 18, 1993. Dr. Stafford was a general surgeon.

Kenneth L. Wagner, MD, *Langhorne*
Temple University School of Medicine, 1964; age 55, died December 27, 1993. Dr. Wagner was a psychiartrist.

Mark S. Winter, MD, *Haverford*
Dartmouth Medical School, 1978; age 39, died November 15, 1993. Dr. Winter was an anesthesiologist.

Charles A. Zammerilla, MD, *New Salem*
Georgetown University Medical School, 1955; age 71, died November 7, 1993. Dr. Zammerilla was a general practitioner.•

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Don't Blame Hillary...

Mike Magee, MD

A voice from within health care encourages physicians and hospitals to unite.

Law: Don't blame Hillary for removing the provider seat from the table. On the community, state, and national levels, we have clearly demonstrated that we will not cooperate with each other. If you were trying to formulate a plan of action to handle the complex and interwoven issues related to health care, would you talk to us? Whether you visit a community hospital, or review a policy set in state and national hospital and medical associations, it is abundantly clear that we can't even agree on what direction to go. We view each other as competitors. Our major motivations have been money and control.

Theorem 1: Our primary energy has been diverted toward facing each other off. If we could capture the energy that we have wasted over the years in confronting each other and direct it positively, there would be no health care crisis. Whether one is in a small 100-bed rural hospital or a complex tertiary teaching institution, our style is fractious, and our approach to problem solving positively inefficient and exhausting. We have made poor use of each other's talents and wasted time in confrontation that might better have been spent in holding a patient's hand, participating on a school board, or contributing to solutions to real health and social issues.

Theorem 2: Our educational framework is archaic, reinforcing old interfaces, a philosophy of separatism and "hold out" postures. In the years I went to medical school, I never came in contact with either a health management or nursing student. Over the following five years of surgical training, I never attended a lecture nor entered into a discussion with the other health professionals at my hospital. I was unaware of their language, approaches, or tools as they were unaware of mine.

More than this, I never heard the leadership within medical staff, management, or nursing recognize this total lack of interdisciplinary orientation and training as an issue. In many medical, nursing, and health management schools today, it remains a non-issue.

Theorem 3: Our patients have grown up and they don't want us at the table. When I was a child in the 1950s, my father was in general practice in an office that was attached to our home. The building and the practice were an extension of his and our lives. The care he provided was heavily humanized and moved in sync with the priorities of his patients and the community.

There was a high degree of trust and a realistic understanding of what was possible. He was as interested in a case of measles as he was in the marital difficulties of a family. His care included mind, body, and soul; money was not an issue. He put in time, huge amounts of time—time to listen, time to touch, time to laugh and cry. He never got exhausted because all the while that he was working, he was being revitalized by patients who cared as much for him as he did for them.

Our patients are looking for that relationship again. The health care revolution in many ways reflects a desire to turn the clock back to a time when doctors gave time.

Theorem 4: Hillary is closer to our patients than we are. It is not she that has denied us a seat, it is "them" and ultimately "us." Our loss of control of the health care transformation has been progressive and predictable. It has spanned three decades, during which we have done little to acknowledge that our patients have grown up and are fully capable of assisting in reordering health care priorities. By diverting our energies away from the challenges of transformation so that we might continue to compete and reinforce roles that are inconsistent with the new spirit of participation and collaboration, we have created our own problem.

The good news is, at the core, we still care. We still possess the needed knowledge. We still have the energy to work together and, if we allow ourselves, to be led by positive leaders.

Dr. Magee is senior vice president at Pennsylvania Hospital, Philadelphia. This article is excerpted with permission from his **Geometry of Physician Relations** *series.*

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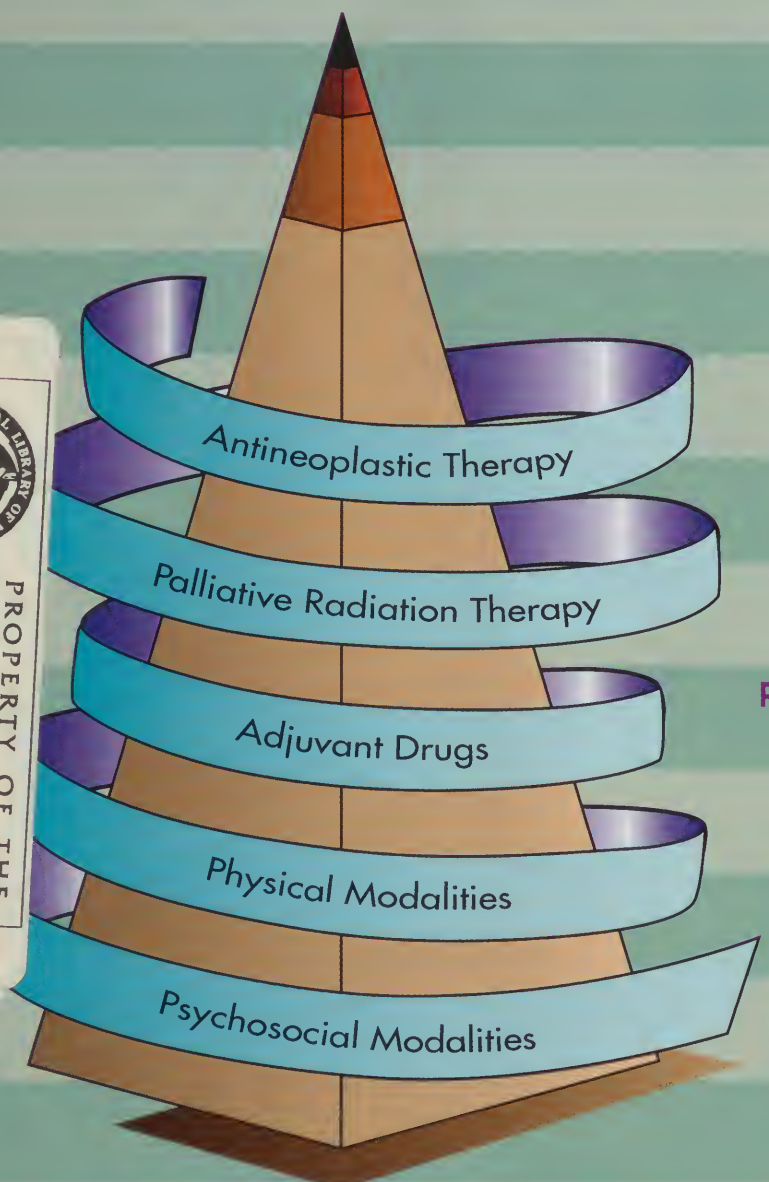
Practice Parameters Come of Age:

A Focus on New Cancer Pain Guidelines–page 18



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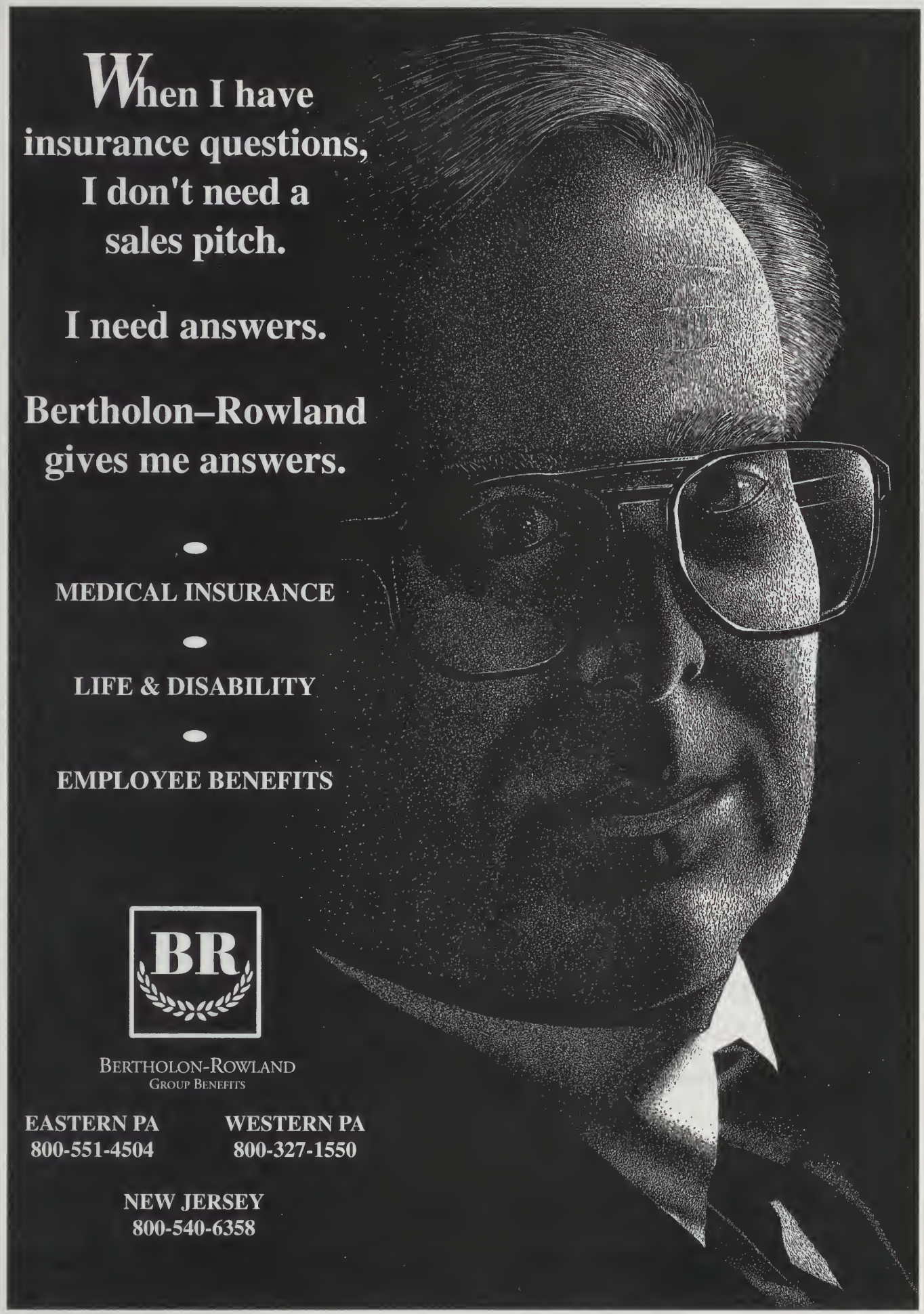
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Pyramid illustration provided by the Agency for Health Care Policy and Research, U.S. Public Health Service

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PMSCO
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After careful study of the changing medical marketplace, the Society's Board of Trustees has established the PennMed Member Services Company (PMSCO) to provide consulting and practice management services to commonwealth physicians.

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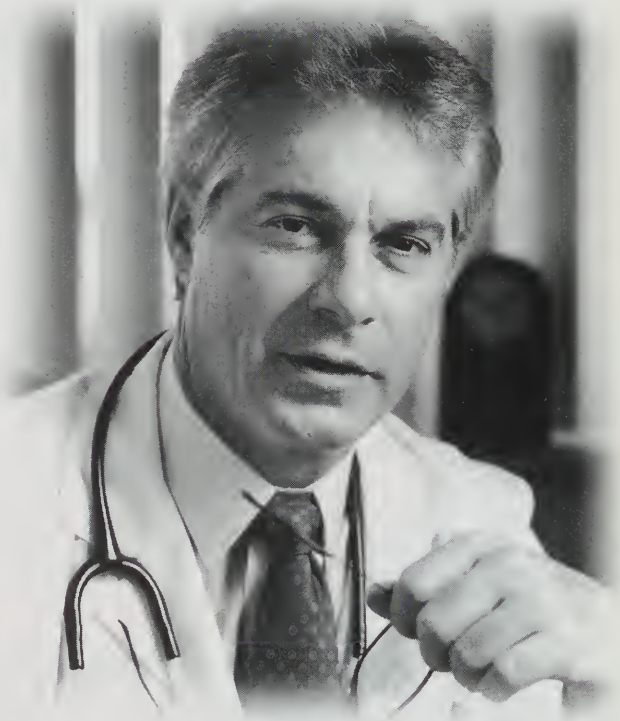
"Unfortunately,

he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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HEARING SET ON MEDICARE LAB OVERPAYMENT ISSUE: Blue Cross-Blue Shield of Maryland—appointed to hear appeals regarding Medicare clinical lab overpayment cases—has set June 3 as the hearing date for the Society's consolidated appeal. The carrier has agreed to permit joint representation of physicians, at no cost to members, for what is probably the most important and universal issue—the "at fault" issue. *Members who have not called or sent in a representation form must do so immediately to assure their inclusion in the appeal.* Inclusion in this appeal would apply to the "at fault" issue only; physicians who wish to raise other issues should consult personal counsel. For Q&A, see page 21.

COMMENTS SOUGHT ON TRAVELERS MEDICARE REIMBURSEMENT: The Pennsylvania Medical Society has learned of instances in which The Travelers Medicare has reimbursed physicians at a level less than that of the federal Medicare fee schedule. The Society contends that a reduced reimbursement is inappropriate and prohibited by federal statute. *Physicians' offices experiencing reduced reimbursement from The Travelers Medicare should call the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.* All concerns will be documented and forwarded to the AMA, which is monitoring the situation and compiling comments to bring to The Travelers.

SENATE TEMPORARILY TABLES OPTOMETRY BILL: The Senate on April 18 temporarily tabled Senate Bill 1061. Strongly opposed by the State Society and the Academy of Ophthalmology, the bill proposes amendments to the Optometry Practice Act to allow the optometric licensure board inappropriate powers to expand an optometrist's scope of practice. The legislation, sponsored by Senator Roy Afflerbach (D-Lehigh), would allow the use of therapeutic pharmaceutical agents by optometrists, without input from any physician in the process of creating clinical training standards. The bill may be brought back to the Senate calendar any time after the Senate resumes session on May 16.

ACTION PROBABLE ON PHYSICAL THERAPIST BILL: Action in the House is probable this spring on House Bill 1531, which would permit physical therapists to diagnose and treat patients without prescription from a physician. The Society, which presented testimony against the bill last summer, continues to oppose the bill. At press time, amendments to the bill were being circulated for comment. Representative Dwight Evans (D-Philadelphia) is prime sponsor.

HEALTH DEPARTMENT PROGRAM PROMOTES HEALTHY BABIES/KIDS: The Pennsylvania Department of Health, Bureau of Maternal and Child Health—in collaboration with other state agencies, the State Society, and other provider and advocacy groups—has developed a statewide outreach project called, "Love 'em with a Checkup." The program offers statewide, toll-free Healthy BABY/Healthy KIDS Help Lines to provide callers with specific information about where they can obtain care and about the programs available in Pennsylvania to pay for care. The Help Line is accessed by calling (800) 986-BABY (for pregnant women) and (800) 986-KIDS (for families with children). Help Line counselors also provide follow-up and advocacy services as needed. Look for a complete overview of the program in PENNSYLVANIA MEDICINE this summer.

DELEGATION PREPARES FOR AMA ANNUAL MEETING: The Pennsylvania Delegation to the AMA will bring 10 resolutions to the AMA's annual meeting, to be held June 18-22, 1994, in Chicago. The resolutions address such issues as tobacco and smoking, violence and the media, health system reform, health insurance choices, physician participation in Project USA, and coding. Elections will also be held during the meeting. Jonathan E. Rhoads, MD, Society vice president and a member of the Society's Board of Trustees, is seeking election to the AMA board; William H. Mahood, MD, Flourtown, is seeking reelection to the Council on Medical Service. Look for coverage of the meeting later this year.

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Keeping Ahead of an Avalanche of Change

John W. Mills, MD
Medical Editor

Our profession is in the throes of change. Nobody really disputes that. In fact, most of our readers might say that is an understatement. The changes that have evolved since the beginning of the century are truly remarkable. Technological advancement has accelerated to mach speed in this century, and we will witness even more rapid change in the twenty-first century.

While we have embraced this rapid advancement, we have had trouble keeping pace in our personal lives. New freedoms, new diseases and illnesses, and serious social, international, and moral questions remain unanswered and threaten our very survival.

"One of the most recent and important actions the board has taken is the formation of a wholly owned, for-profit subsidiary... known as PMSCO."

So it is with medicine. We are proud of our U.S. health care system—the envy of the world. But we have some serious problems in our arena, most of which stem from great technological advances in medicine. We can never revert to former years, and we wouldn't want to; the status quo would be unacceptable. Nostalgia nudges us back at times, but we know it's really one of our defense mechanisms when we are pushed along by our modern way of life.

That's been one of the AMA's problems in times past—failure to move ahead with the advancement. However, I do feel they have gotten the message, perhaps spurred on by health system reform. Likewise, the State Society has become upbeat, progressive, and much more responsive to members' needs in the past decade.

This is not meant as criticism of either group, but rather to point out that change and advancement are taking place rapidly now in an effort to portray an effective organization of physicians and *for physicians.* Neither organization can be characterized now as a stodgy male conclave, bent on the status quo.

Your Board of Trustees seeks to address the myriad changes affecting Pennsylvania physicians both on the state and national level. A biannual board retreat looks with an in-depth focus at the changing face of medicine.

Our executive vice president, Roger Mecum, continues to organize our State Society staff, in light of the ever-changing medical scene, to help position us as Pennsylvania's medical "spokesgroup" par excellence. His contacts "on the hill" in Harrisburg, as well as those with labor, industry, and insurance, have helped immeasurably to keep Pennsylvania physicians on equal terms in health care issues. Along with the board, Roger has helped us keep a steady helm in the stormy sea of health system reform swirling around us.

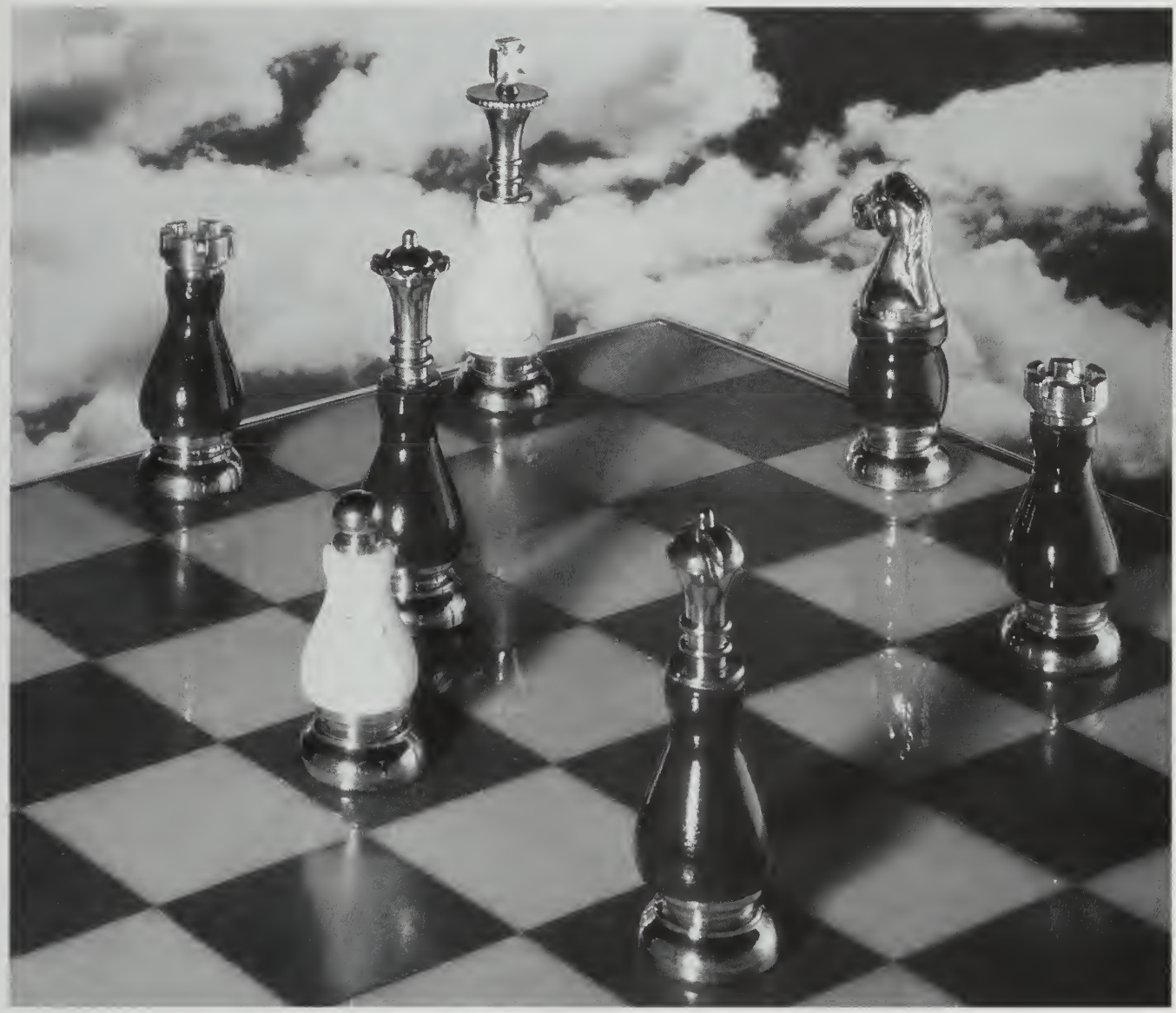
Our board retreat will be in July this year. We will be taking a hard look at focusing our resources and efforts in more effective ways for you, our members. Regional presence out of Harrisburg, structural changes, representative leadership, and enhancing membership value are some of the issues we'll be wrestling with.

One of the most recent and important actions the board has taken is the formation of a wholly owned, for-profit subsidiary, similar to PMSLIC and KePRO, known as PMSCO—PennMed Member Services Company (see page 24).

PMSCO's main effort is to help physicians organize into effective groups so that they can deal as a legal entity with hospitals to form physician-hospital organizations (PHOs), or to contract with insurers to provide health care services for employees or other groups. Initially, implementation of network consulting services is to be PMSCO's top priority, along with completion of the management service organization's business plan.

If county medical societies or hospital medical staffs are interested in learning more about forming effective physician organizations, call the Society to schedule a speaker who will discuss integration options for physicians and what services PMSCO can provide. Rest assured, fees will be extremely competitive for State Society members. The advice and expertise will be top notch.

Change? Yes, we're in an avalanche of change. Don't be swept away, for the maze out there is formidable. Let your Society help you chart a successful course into the twenty-first century.



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The Ugly Side of Reform

Martin A. Murcek, MD

"The rising level of discomfiture about the 'plan' among our elected representatives shows that some of them are having second thoughts as well."

This month, I want to take a look at the ugly side of the health system reform debate. I say ugly, because the story that follows is full of mean-spirited childishness, hypocrisy, name-calling, and holier-than-thou-ism.

On February 21 of this year, the *Philadelphia Inquirer* printed a letter to the editor from William S. Frankl, MD, president of the Philadelphia County Medical Society. In his letter, Dr. Frankl raised some honest and straightforward questions about the inordinate praise being lavished on the Clintons' "reform" plans by liberal commentators and reporters. Dr. Frankl pointed out that such items as the rising divorce rate, single-parent families, teen pregnancies, drug abuse, child abuse, and criminal violence are not health care issues, per se.

In the same letter, Dr. Frankl pointed out that Mrs. Clinton's claim that the "economic" side of the health care equation could be changed without affecting the patient care side was disingenuous at best. The strongest language Dr. Frankl used in his letter was the use of the word *dissembling* to describe the pronouncements of Hillary et al. vis-a-vis health system reform.

Dr. Frankl's letter stirred up a real progressive hornets' nest at the *Inquirer*. In an editorial published in that "paper" (their term, not mine), the editorialist accused Dr. Frankl of "not listening" while attending medical school and of "working himself into a lather" about issues that St. Hillary allegedly never made pronouncements upon.

The editorialist excoriated Dr. Frankl for bringing that nasty word, "choice," into the argument, claiming that choices, as they have existed in the past, are disappearing anyway. On the whole, the piece was a plain, old-fashioned, yellow-journalism smear.

Of course, as Whitewater and other presidential escapades of the Clintons' come to light, it doesn't seem very harsh to label them disingenuous. Liberal editorialists are now admitting that all is not well with their "dream team" and that maybe some tough questions ought to be asked. It's still soft-pedaling, but it's a start.

The *Inquirer* printed on March 4 a rebuttal letter from Dr. Frankl which pointed out that many other editorialists around the country had recently lodged misgivings similar to his own about the Clinton "plan." As he did in his original letter, Dr. Frankl pointed out that honest debate of the health system reform issue should not be harmful to anyone supporting such reform for honest reasons.

The issue of honesty brings us to the rub: I have said from the beginning that the health system reform issue is about money only and has nothing to do with the well-being of the citizenry at large. This fact is still being denied by the Clintons' backers, but the polls show that the public at large isn't buying it anymore. The rising level of discomfiture about the "plan" among our elected representatives shows that some of them are having second thoughts as well.

Objectivist philosopher and noted author Ayn Rand once said that it would be easy to tell when our government officials were going completely around the bend, by observing their increasing confusion over what constitutes a want as opposed to a need.

Today, people want to abuse their bodies in a wide variety of ways at no consequence to themselves: They want to smoke cigarettes, but have the pulmonary function of a marathon runner; they want to suck fat out of a bucket through a straw without worrying about obesity or heart disease; they want to consume dangerous drugs and alcohol during pregnancy without concern about the prenatal mess they are creating inside themselves. Worst of all, the government wants to make it financially painless for them to do so. These are all manifestations of Rand's wants/needs dichotomy and worthy of profound consideration.

Long after the ingrates serving as mouthpieces for the Clintons' flawed "plan" are forgotten, good doctors like Bill Frankl will still be valued by their patients who know that their physician's devotion is to the diminishment of human suffering, not the almighty dollar.

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LETTERS TO THE EDITOR

AMA: DISCONTINUE NATHAN DAVIS AWARDS

As a Pennsylvania physician, my nominations for the 1995 Nathan Davis Awards are: state Representative Allen Kukovich (D-Westmoreland) and U.S. Congressman Fortney Pete Stark (D-California).

Since 1989, the American Medical Association (AMA) has annually presented the Nathan Davis Awards to public officials who have contributed significantly to further public health. In this short period, Senator Edward Kennedy (D-Massachusetts) (1992), Kentucky's Governor Brereton Jones (1994), and Hawaii's Director of Health John Lewin, MD (1994), have received this prestigious honor. Did these three individuals deserve this award? The answer is, No!

Dr. Lewin was chosen for his implementation of the Hawaiian State Health Insurance Program, which began in 1974. This system, contrary to its many advocates, is restrictive and repressive. Two health care carriers, Kaiser Permanante and Blue Shield, control 80 to 95 percent of the health care market. The average time a physician practices in Hawaii is six years, and the state has a greater emigration of doctors than any other. Half of all the hospitals are state owned, and Hawaii has a value-added tax. Does this illustrate that Dr. Lewin deserves the Nathan Davis Award?

Since the early 1970s, Senator Kennedy has promoted a national health care system that is socialistic in its concept. Does he merit the Nathan Davis Award?

Governor Jones pressured the Kentucky legislature to pass his health care reform bill, which included a two-percent provider tax on gross revenue that could not be passed onto the public. There would be a five-person health board that could set rates, grant medical licenses based on economic efficiency, and review patient-physician records. The law, which was enacted in 1993 before being overturned in state circuit court, also prohibited balance billing by physicians and mandated health care participation by each household. Has Governor Jones contributed much to receive the Nathan Davis Award?

Of the eight members on the AMA's Nathan Davis Awards' board, only three are AMA physicians. Of the remaining five, Howard Deets, executive director of the American Association of Retired Persons, is a member. Is he entitled to select from the nominations for the Nathan Davis Awards? When Governor Jones was confirmed, all three AMA officials voted, No!

For 1995, let us continue the present tradition, and nominate Allen Kukovich and Pete Stark for the Nathan Davis Awards! Or should the AMA discontinue these presentations?

Joseph A. Giordano, MD
Sharon

AUTHOR AVAILABLE TO SPEAK ON FUTILITY

I have received a number of positive comments about PENNSYLVANIA MEDICINE's reprint of the point-counterpoint articles on futility which appeared in the February 1994 issue ["The Concept of Futility...," pages 18-29].

As follow-up, I would like to mention that one of the authors, James F. Drane, PhD, is available to talk to county medical societies and other interested groups, including hospital medical staffs or hospital ethics committees, about futility and other bioethical issues. One of his main themes is to point out in a very dynamic presentation a number of bioethical myths that the medical profession clings to.

For information, call Dr. Drane directly at (814) 732-2604 or (814) 734-1443.

John W. Mills, MD
Medical Editor

Speak Out on Managed Care

PENNSYLVANIA MEDICINE wants to hear from you about managed care.

Managed care is everywhere. How is it impacting your practice? What questions do you have about integrating your practice into the new arenas of managed care, hospital mergers, and physician networks? Are you confused? Let us know! The State Society and this publication continue to present news and views of the issues, so you know what we think! But what do you think? What are your:

- thoughts and concerns?
- suggestions for improvement?
- efforts towards improvement?
- reactions to the State Society's positions?
- reactions to our coverage of the issues?

Let us know!

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New Therapeutic Agents Marketed in 1993

Daniel A. Hussar, PhD

This is the second in a series of articles overviewing new drugs marketed in the U.S. in 1993.

In 1993, the Food and Drug Administration (FDA) approved 25 new molecular entities (NMEs), 23 of which are for therapeutic use and two are diagnostic agents. Eleven of the NMEs for therapeutic use, as well a new biological agent intended for therapeutic use, were both approved and marketed in the United States in 1993. In addition, 11 other NMEs that the FDA approved before 1993 (most in late 1992) were marketed during the year. Thus, a total of 23 therapeutic agents reached the U.S. market for the first time in 1993, a considerably lower number than the 30 new therapeutic agents marketed in 1992 and the record number 31 new agents marketed in 1991. Many of the 13 therapeutic agents approved in 1993 but not marketed before the end of the year have become available in early 1994.

This review of the therapeutic agents first marketed in 1993 considers their most important properties and, when possible, compares them with other available agents with similar properties. Of the 23 new therapeutic agents, 22 are considered in this paper. The one agent not reviewed is flosequinan, which was withdrawn from the market after being available only several months because of a concern about toxicity. This discussion of new drugs focuses on the most important properties of these agents; when additional information is needed, more comprehensive references and the product literature should be consulted.

Hypnotic

Zolpidem tartrate (Ambien-Searle) is an imidazopyridine derivative that is indicated for the short-term treatment of insomnia. Although it is structurally unrelated to the benzodiazepines (e.g., triazolam [Halcion]) and other hypnotics, it binds to benzodiazepine receptors (also known as omega receptors) in the brain and shares some of the pharmacological properties of the benzodiazepines. Zolpidem is effective in inducing and maintaining sleep and, in comparative studies, it has been as effective as the benzodiazepine derivatives. The new drug has a rapid onset of action, a short half-life, and no active metabolites, and, like triazolam, is unlikely to cause residual next-day sedation.

The adverse reactions most commonly associated with the use of short-term treatment (up to 10 nights) with zolpidem in doses up to 10 mg, and seen at statistically significant differences from placebo-treated patients, include drowsiness (two percent), dizziness (one percent), and diarrhea (one percent). There has been little evidence of memory impairment, or rebound effects when therapy was discontinued, when zolpidem has been used in the recommended dosage (i.e., up to 10 mg). However, if the dosage exceeds this level, the frequency of the abovementioned effects increases, and there is also an increased risk of problems such as confusion and falls in elderly patients.

Although zolpidem is used to induce and maintain sleep, patients should be cautioned against engaging in activities requiring complete mental alertness or motor coordination, such as operating machinery or driving, after ingesting the drug (including potential impairment of the performance of such activities the following day). Patients should also be warned about the risk of additive depressant effects when other agents with central nervous system (CNS) depressant activity are used concurrently. It is recommended that the consumption of alcoholic beverages be avoided during treatment with zolpidem, as well as other hypnotics.

Problems of dependence and abuse have occurred with the benzodiazepines, and these agents are included in Schedule IV under the provisions of the Controlled Substances Act. It has been suggested that the potential for abuse of zolpidem is less than that for the benzodiazepines, particularly since high doses of zolpidem often cause nausea and vomiting. However, like the benzodiazepines, zolpidem is classified in Schedule IV, and similar precautions should be observed.

Most of the benzodiazepines are included in Pregnancy Category X, and their use during pregnancy is contraindicated. Zolpidem is included in Pregnancy Category B, and, unlike the benzodiazepines, its use is not contraindicated during pregnancy. Nevertheless, the new drug should be used during pregnancy only if clearly needed.

Because zolpidem has a rapid onset of action, it should only be taken immediately prior to going to bed. Food may delay and/or decrease absorption and, for faster sleep onset, zolpidem should not be administered with or immediately after a meal. The recommended adult dosage is 10 mg immediately before bedtime, which is also the maximum recommended dose. A lower dosage may be necessary in patients who are also taking other CNS depressants. An initial 5-mg dose is recommended in patients with hepatic insufficiency and in elderly or debilitated patients who may be especially sensitive to the effects of zolpidem.

The use of hypnotics such as zolpidem should generally be limited to a period of seven to 10 days. Reevaluation of the patient is advised if a hypnotic is to be taken for more than two to three weeks. It is recommended that zolpidem not be prescribed in quantities exceeding a one-month supply.

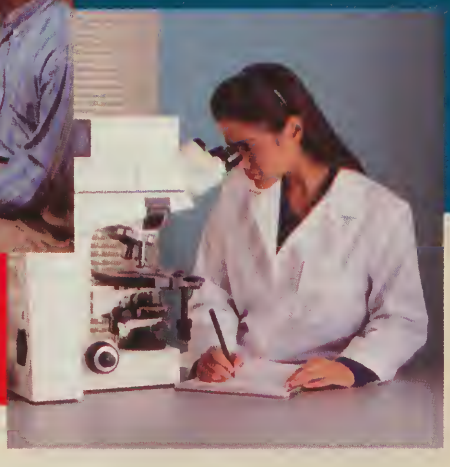
Zolpidem tartrate tablets are supplied in 5- and 10-mg potencies.

Antiepileptic agent

About 2.5 million Americans have epilepsy. Although the seizures of many patients are well controlled with medication, it is estimated that between 20 and 30 percent of patients are poorly controlled and continue to experience seizures even with the use of medication. *Felbamate* (Felbatol-Wallace) is the first new antiepileptic drug to be marketed in 15 years and is structurally related to meprobamate (Equanil, Miltown). It has a broad spectrum of anticonvulsant activity and, although the mechanism by which it exerts its activity is unknown, it may reduce seizure spread and increase seizure threshold.

The new drug has been approved for use as monotherapy and adjunctive therapy in the treatment of partial seizures with and without generalization in adults (14 years of age and above) with epilepsy. It is also indicated as adjunctive therapy in the treatment of partial and generalized seizures associated with Lennox-Gastaut syndrome in children (ages 2-14 years). Lennox-Gastaut syndrome involves multiple seizure types and occurs almost exclusively in children.

In the clinical studies, felbamate was effective in a number of patients whose seizure disorders were poorly controlled by other drugs, and it represents an important addition to the group of agents that are effective in the management of epilepsy. It also was well tolerated by most patients and appears less likely than some of the other antiepileptic drugs (e.g., phenytoin [Dilantin]) to cause neurologic/cognitive problems such as difficulty thinking clearly, memory loss, depression, or slurred speech.



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The adverse reactions most often reported when felbamate was used alone in adult patients in the clinical trials include anorexia, nausea, vomiting, dyspepsia, constipation, fatigue, insomnia, and headache. These effects occurred in less than 10 percent of patients, and it was seldom necessary to discontinue therapy. Because felbamate is not likely to cause serious toxicities, it is not necessary to monitor plasma concentrations since dosage is titrated to the clinical response instead of to specific ranges of plasma concentrations.

The use of felbamate in conjunction with other antiepileptic drugs must be approached with caution because of the potential for drug interactions. Felbamate causes an increase in the plasma concentrations of phenytoin, valproate (Depakene, Depakote), and the active epoxide metabolite of carbamazepine (Tegretol), although the concentration of carbamazepine itself is reduced. It is recommended that when felbamate is added to or substituted for other antiepileptic drugs, the dosage of the other agents should be reduced by 20 to 33 percent to minimize the occurrence of adverse effects. The activity of felbamate may also be changed as a result of interaction with other antiepileptic drugs. Phenytoin and carbamazepine increase the clearance and reduce the plasma concentrations of felbamate by 45 percent and 40 percent, respectively, whereas valproate is not likely to cause a clinically important change in felbamate concentrations.

In the clinical studies of felbamate, most patients received 3,600 mg/day in both monotherapy and adjunctive therapy regimens. When the treatment of a seizure disorder in an adult is to be initiated with felbamate monotherapy, the recommended starting dosage is 1,200 mg/day in divided doses three or four times a day. The dosage may then be increased in 600-mg increments every two weeks to 2,400 mg/day based on clinical response and thereafter to 3,600 mg/day if indicated. The product labeling should be consulted for dosage recommendations for adult patients treated with other antiepileptic drugs who are to be converted to felbamate monotherapy, and for patients in whom felbamate is to be used as adjunctive therapy.

Felbamate tablets are supplied in 400- and 600-mg potencies, and an oral suspension (600 mg/5 ml) is also available.

Agent for multiple sclerosis

Interferon beta-1b (Betaseron-Berlex) is an analog of human interferon beta that is produced using recombinant DNA technology. The interferons are a family of naturally occurring proteins that have been grouped in three major classes—alfa, beta, and gamma. The interferons have overlapping yet distinct biologic activities. Interferon beta-1b is the fifth interferon and the first beta interferon to be marketed in the U.S., and it exhibits both antiviral and immunoregulatory actions.

The use for which interferon beta-1b has been approved is unique, not only among the interferons but among all therapeutic agents. Although several other agents have been used in the management of the symptoms of multiple sclerosis (MS), interferon beta-1b is the first drug to be specifically approved for the treatment of MS. The new drug is indicated for use in ambulatory patients with relapsing-remitting multiple sclerosis to reduce the frequency of clinical exacerbations.

About 300,000 Americans have MS, and it most commonly strikes young adults. The specific cause is unknown, but it is thought to be an immunologically mediated disorder that results in damage to the nervous system with the potential for disability. Approximately 100,000 individuals experience the relapsing-remitting form of MS that is characterized by recurrent attacks (relapses or exacerbations) of neurologic dysfunction followed by complete or incomplete recovery (remissions). The relapses that are experienced may involve vision problems, slurred speech, muscle weakness, lack of motor coordination, and/or tremors.

In the clinical studies, interferon beta-1b reduced the frequency of MS attacks by one-third and of serious attacks by one-half, and also reduced the need for hospitalization. In addition, magnetic resonance imaging (MRI) studies showed a significant decrease in MS lesions. The beneficial results with the use of interferon beta-1b are thought to be primarily due to its immunoregulatory action, although the specific mechanism by which it acts is not known.

Interferon beta-1b represents an important breakthrough in the management of multiple sclerosis and offers hope for individuals with a disorder for which no effective treatment was previously available. However, its limitations must also be recognized. It is not a cure for MS. The percentage of patients who became more disabled was only slightly lower in the treated group than in the placebo group in the clinical studies, and some patients have not benefited from the use of the new drug. The efficacy of interferon beta-1b in the treatment of the more serious chronic-progressive form of MS has not yet been determined, and studies are currently being conducted in patients with this form of the disease.

Interferon beta-1b is administered subcutaneously, and injection site reactions (e.g., redness, pain, swelling, discoloration) were experienced by 85 percent of the patients in the clinical studies, with injection site necrosis occurring in five percent. In most patients these reactions were transient and did not require discontinuation of therapy. Patients should be advised regarding the rotation of injection sites and cautioned against administering injections into skin that is tender, red, or hard.

As with the other interferons, flu-like symptoms (fever, chills, myalgia, malaise, sweating) are common with the use of interferon beta-1b, having been experienced by about 75 percent of patients. Administering the medication at night may help lessen the impact of flu-like symptoms as may the use of acetaminophen.

Some patients in the clinical studies experienced mental disorders, including confusion, anxiety, and depression. One suicide and four attempted suicides were also reported; although it is not known whether interferon beta-1b was implicated in these actions, patients should be warned to immediately report symptoms of depression or suicidal ideation. Patients exhibiting depression should be monitored closely, and discontinuation of therapy should be considered.

Although interferon beta-1b was not observed to be teratogenic in animal studies, it exhibited an abortifacient action. It is classified in Pregnancy Category C, and patients should be advised of its abortifacient potential. If the patient becomes pregnant or plans to become pregnant while taking interferon beta-1b, it should be recommended that the patient discontinue therapy.

The recommended dosage of interferon beta-1b is 0.25 mg (8 million international units [IU]) injected subcutaneously every other day. Patients should be instructed in injection techniques to assure the safe self-administration of the drug. Sites for self-injection include the arms, abdomen, hips, and thighs. Interferon beta-1b is supplied as a lyophilized powder in vials containing 0.3 mg (9.6 million IU) of the drug. The vials should be stored in a refrigerator but should not be frozen.

At this time, the supply of interferon beta-1b falls far short of the amount needed. Following a request to physicians to "register" patients for whom they wished to prescribe the drug, more than 50,000 patients were enrolled and randomly assigned a position on the enrollment list. Berlex and Chiron (the company that is manufacturing the drug) expect to be able to supply 25,000-40,000 patients by the end of 1994, and

over 100,000 patients by the end of 1995. Interferon beta-1b is distributed through a network of pharmacies participating in the PCS Biotech Network administered by PCS Health Systems.

Agent for Alzheimer's disease

Tacrine hydrochloride (Cognex-Parke-Davis), also known as tetrahydroaminoacridine or THA, is the first drug to be approved for the treatment of Alzheimer's disease. Characterized by a progressive decline in memory, judgment, the ability to reason, and intellectual function, Alzheimer's disease afflicts approximately four million American adults. More than 100,000 people die from this disorder each year, making it the fourth leading cause of death in adults after heart disease, cancer, and stroke.

The cause of Alzheimer's disease is not known, but it has been suggested that the symptoms are due, in part, to a deficiency of acetylcholine in the brain. Tacrine is a reversible cholinesterase inhibitor that presumably acts by elevating acetylcholine concentrations in the cerebral cortex by slowing the degradation of acetylcholine by still intact cholinergic neurons. The new drug is specifically indicated for the treatment of mild to moderate dementia of the Alzheimer's type. In the clinical studies, it was found to provide a small but clinically significant benefit in improving memory and reasoning ability.

The marketing of tacrine represents an important advance in the treatment of Alzheimer's disease; however, it is not a cure for the disorder, nor is there evidence that the drug alters the course of the underlying dementing process. Indeed, in the clinical studies with the drug, the use of the highest recommended dosage (160 mg per day) resulted in significant improvement in only about 40 percent of the patients. Nevertheless, the use of tacrine offers the potential for clinical benefit in a disorder for which no effective treatment was previously available.

The primary concern with the use of tacrine is the risk of liver toxicity. Approximately 50 percent of patients in the clinical studies experienced alanine aminotransferase (ALT) elevations above the upper limit of normal (ULN), although only one of more than 8,000 patients in the studies had documented elevated bilirubin levels (5.3 times the ULN) and jaundice with transaminase levels nearly 20 times the ULN. It is recommended that serum transaminase levels (specifically ALT) be monitored weekly for at least the first 18 weeks following initiation of tacrine treatment, after which monitoring may be decreased to every three months. Weekly monitoring should be resumed for a minimum of six weeks on each occasion that the dose of tacrine is increased. When transaminase levels rise to between three and five times the ULN, the dose of tacrine should be reduced by 40 mg/day. Dose titration can be resumed when the transaminases return to within normal limits. It is recommended that tacrine therapy be stopped if transaminase levels exceed five times the ULN.

Other commonly reported adverse reactions with the use of tacrine include gastrointestinal effects (nausea and/or vomiting [28 percent], diarrhea [16 percent], dyspepsia [nine percent], anorexia [nine percent]), which are due at least in part to the cholinergic action of the drug.

Tacrine is extensively metabolized by the cytochrome P450 enzyme system, which is also involved in the metabolism of agents such as theophylline. The concomitant use of tacrine with theophylline has increased the average plasma theophylline concentrations by about two-fold. Therefore, the monitoring of plasma theophylline concentrations and the appropriate reduction of theophylline dosage are recommended in patients taking the two drugs concurrently. Cimetidine, by inhibiting liver enzyme systems, has been reported to increase the peak serum concentration of tacrine by 54 percent. Cigarette smoking is known to increase liver enzyme activity, and the mean plasma tacrine concentrations in current smokers are approximately one-third the concentrations in nonsmokers.

Food reduces tacrine bioavailability by about 30 to 40 percent; however, there is no food effect if the drug is administered at least an hour before meals. Tacrine should be taken between meals whenever possible but, if gastrointestinal upset occurs, the drug may be taken with food to improve tolerability although a significant reduction in plasma concentrations should be expected.

The initial dosage of tacrine is 10 mg four times a day. Following six weeks of treatment, the dosage should be increased to 20 mg four times a day, providing there are no significant transaminase elevations and the patient is tolerating treatment. Patients should be titrated to higher doses (30 mg four times a day and then 40 mg four times a day) at six-week intervals on the basis of tolerance.

Capsules of tacrine hydrochloride are supplied that contain 10, 20, 30, and 40 mg of tacrine. The cost of all four potency capsules is the same so that the titration to higher dosage levels is not associated with a higher cost that would discourage patient compliance.

Antidepressant

Paroxetine hydrochloride (Paxil-Smith-Kline Beecham) is the third selective serotonin reuptake inhibitor (SSRI) to be marketed in the U.S., joining fluoxetine (Prozac) and sertraline (Zoloft). Although it is structurally unrelated to other available antidepressants, its mechanism of action and many of its properties are similar to those of the other SSRIs.

Paroxetine is indicated for the treatment of depression and, in the clinical studies of its use in patients with major depressive episodes, the new agent was generally found to be as effective as fluoxetine and imipramine (Tofranil). The use of paroxetine has also been evaluated in patients with other disorders such as obsessive-compulsive disorder, panic disorder, and diabetic neuropathy. However, these are not labeled indications at the present time.

The most commonly observed adverse reactions in the clinical trials (with an in-

Studies Consider Tacrine's Risks

CHICAGO—High doses of the Alzheimer's drug, tacrine, have been found to be safe and effective for some patients, although the potential for serious, but reversible, liver toxicity exists, according to two *JAMA* studies published April 6, 1994.

One study examined the efficacy and safety of high-dose tacrine in patients with probable Alzheimer's disease. "Patients treated with 160 mg/d of tacrine showed statistically significant and clinically observed improvements on objective cognitive tests, clinician- and caregiver-rated global evaluations, and quality of life assessments," write the authors. "A statistically significant dose-response relationship and a substantially larger treatment effect than those reported in previous studies suggest that higher doses of tacrine are more beneficial than lower doses."

In the second study, levels of ALT, an enzyme whose serum concentration increases in cases of liver injury, were measured. "Elevated ALT levels appeared to be a delayed manifestation of tacrine therapy," the authors say. "In every patient who had an ALT level greater than three times the upper limit of normal, levels returned to normal after tacrine therapy was discontinued...For most patients, the elevations in ALT level will be mild and will resolve with discontinuation of therapy or reduction in drug dose. Nonetheless, the marked interpatient differences in susceptibility make it likely that tacrine could produce life-threatening hepatotoxicity in some patients." The authors suggest careful monitoring of serum ALT levels.

cidence at least twice that for placebo) were nausea (26 percent), decreased appetite (six percent), asthenia (15 percent), somnolence (23 percent), dizziness (13 percent), insomnia (13 percent), tremor (eight percent), sweating (11 percent), and ejaculatory disturbance (13 percent). Paroxetine should not be used concomitantly with a monoamine oxidase inhibitor (MAOI) such as tranylcypromine (Parnate), or during either the 14-day period following discontinuation of treatment with a MAOI or the 14-day period preceding initiation of treatment with a MAOI. Although paroxetine has not been shown to increase the effects of alcohol, patients should be advised to avoid the consumption of alcoholic beverages while taking the new agent.

The possibility of a suicide attempt is inherent in depression, and close supervision of high-risk patients should accompany initial therapy with paroxetine. Prescriptions should be written for the smallest quantity of tablets, consistent with good patient management, to reduce the risk of overdosage.

Paroxetine is extensively metabolized in the liver. Cimetidine has been reported to inhibit its metabolism and to increase its steady-state plasma concentrations by about 50 percent, and a reduction in dosage of the antidepressant may be necessary. Conversely, phenobarbital and phenytoin (Dilantin) may increase the activity of hepatic enzyme systems, and accelerate the metabolism and reduce the activity of paroxetine, possibly necessitating an increase in dosage.

Like fluoxetine, paroxetine itself may inhibit the activity of liver enzyme systems, and its concurrent use with other medications that are metabolized by these enzymes must be closely monitored. Of the three SSRIs, sertraline appears to be the least likely to affect liver enzymes and to interact with other drugs via this mechanism.

Like sertraline, the elimination half-life of paroxetine is considerably shorter than that of fluoxetine. This can be advantageous in certain situations, such as when a SSRI is discontinued and treatment with a MAOI is to be initiated. Because of its long elimination half-life, at least a five-week interval should elapse after discontinuing fluoxetine before initiating treatment with a MAOI.

Paroxetine is administered as a single daily dose, usually in the morning to reduce the possibility of adverse reactions like insomnia. However, if a patient experiences somnolence, the drug may be taken at bedtime. For patients who experience nausea, administering paroxetine with food may minimize the potential for this effect. The usual initial dose is 20 mg/day. As with other antidepressants, the full therapeutic effect usually occurs within two to four weeks after treatment is started. In patients for whom the initial dosage does not provide an adequate response, the dosage may be increased in 10 mg/day increments to a maximum of 50 mg/day. Dosage changes should occur at intervals of at least one week.

Tablets are available in two potencies that contain paroxetine hydrochloride in an amount equivalent to 20 mg and 30 mg of paroxetine.

Anti-inflammatory agent

Oxaprozin (Daypro-Searle) is a nonsteroidal anti-inflammatory drug (NSAID) in the propionic acid derivative class, joining fenoprofen (Nalfon), flurbiprofen (Ansaid), ibuprofen (Motrin), ketoprofen (Orudis), and naproxen (Naprosyn). Like the other NSAIDs, the new agent exhibits anti-inflammatory, analgesic, and antipyretic activities. Oxaprozin is indicated for acute and long-term use in the management of osteoarthritis and rheumatoid arthritis. Its effectiveness in these disorders appears to be similar to that of aspirin and other NSAIDs.

The risks and precautions associated with the use of oxaprozin are generally similar to those for other NSAIDs. It is contraindicated in patients with the complete or partial syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin or other NSAIDs, because of the risk of severe asthmatic or anaphylactic reactions.

As with other NSAIDs, gastrointestinal (GI) effects, including nausea (eight percent), dyspepsia (eight percent), constipation (three to nine percent), diarrhea (three to nine percent), abdominal pain/distress, anorexia, flatulence, and vomiting (each one to three percent), are the adverse reactions most often associated with the use of oxaprozin. Any NSAID must be used with caution, if at all, in patients with a history of a serious GI disorder.

Drugs that inhibit prostaglandin synthesis may cause harm to a fetus, and it is recommended that the use of oxaprozin during late pregnancy be avoided. The concurrent use of oxaprozin and aspirin is not recommended because oxaprozin displaces salicylates from plasma protein binding sites and increases the risk of salicylate toxicity.

Oxaprozin has a duration of action that is long enough to enable once-daily administration. Although most patients do not experience adverse reactions when oxaprozin is administered once a day, divided doses may be tried in patients who are unable to tolerate larger single doses.

The usual dosage of oxaprozin in the treatment of rheumatoid arthritis and moderate to severe osteoarthritis is 1,200 mg once a day. In patients with milder osteoarthritis or who are of low body weight, an initial dosage of 600 mg once a day may be appropriate. Doses higher than 1,200 mg/day should be reserved for patients who weigh more than 50 kg, have normal renal and hepatic function, are at low risk of developing a peptic ulcer, and whose severity of disease justifies the higher dosage. The maximum recommended total daily dose is 1,800 mg, or 26 mg/kg, whichever is lower, administered in divided doses. Because of the long half-life of oxaprozin, it takes several days of therapy to reach steady state and for the full effects of the drug to develop. For a faster onset of action, an 1,800-mg loading dose can be given.

Oxaprozin caplets are supplied in a 600-mg potency.

Agent for migraine

Approximately 23 million adult Americans suffer from migraine, and almost one-half of these individuals suffer moderate to severe disability as a result of these headache attacks. The treatment of acute migraine has primarily involved the use of analgesics (aspirin, acetaminophen), NSAIDs (e.g., ibuprofen, naproxen), ergotamine tartrate or dihydroergotamine (DHE-45), or combination products containing isometheptene mucate (Midrin). However, for many migraine sufferers, these agents have not provided adequate relief from the headache attacks and/or have caused significant adverse reactions. It is for these reasons that the marketing of *sumatriptan succinate* (Imitrex-Cerenex) has been greeted with such great expectations and publicity.

Sumatriptan is chemically related to serotonin, also known as 5-hydroxytryptamine or 5-HT. Although the pathophysiology of migraine is still incompletely understood, there is considerable evidence that serotonin is involved, and the specific role of this neurotransmitter is the subject of continuing studies. There are four main types of 5-HT receptors and within each type are distinct subtypes. It is thought that certain intracranial blood vessels are dilated during a migraine attack and that 5-HT_1 receptors can mediate vasoconstriction of these vessels. Sumatriptan is a selective 5-HT_1 receptor agonist and exerts its antimigraine effect by activating these receptors and causing vasoconstriction. Because sumatriptan selectively acts at 5-HT_1 receptors and does not have a significant affinity for other receptors, it appears less likely to cause certain of the adverse reactions associated with the ergot derivatives.

Sumatriptan is indicated for the acute treatment of migraine attacks with or without aura and is administered by subcutaneous injection. Following injection, the onset of pain relief is rapid, often beginning within 10 minutes. In two controlled clinical trials involving more than 1,100 patients with moderate to severe migraine pain, headache relief (as evidenced by a reduction in pain from severe or moderately severe to mild or no headache) was achieved in 70 percent of patients within one hour of injection of a 6-mg dose, and in 82 percent of patients within two hours. The drug also relieved the nausea, vomiting, photophobia, and phonophobia (sound sensitivity) associated with migraine attacks. Although studies which directly compare sumatriptan and other agents are limited, for many patients the new agent has been more effective and/or better tolerated than other treatments for migraine, and it represents an important addition to the small group of agents that may be used for the management of acute migraine attacks.

Sumatriptan may also be effective in the treatment of cluster headache, a problem for which other medications are often ineffective. However, additional studies are needed, and this is not a labeled indication for the drug at this time.

The adverse reactions most often associated with the use of sumatriptan include pain or redness at the injection site (59 percent); atypical sensations (e.g., sensations of warmth [11 percent], tingling or paresthesia [14 percent], pressure [seven percent], burning [eight percent], numbness [five percent], tightness [five percent], all of which may be localized or generalized); dizziness (12 percent); and chest discomfort (i.e., pressure, tightness, or pain [five percent]). All of these reactions are usually transient although they may be severe in some patients.

Although serious coronary events following sumatriptan injection are rare, the drug has the potential to cause coronary vasospasm and should not be given to patients with ischemic heart disease (angina pectoris, history of myocardial infarction, or documented silent ischemia), patients with Prinzmetal's angina, or patients with signs or symptoms consistent with ischemic heart disease. It is recommended that ergotamine and sumatriptan not be used within 24 hours of each other, because ergot-containing drugs have been reported to cause prolonged vasospastic reactions and because of the possibility that this action may be additive to that of sumatriptan.

Sumatriptan is administered by subcutaneous injection in the lateral thigh or deltoid area of the arm. The recommended adult dose of sumatriptan is 6 mg. Most patients experience headache relief following the initial injection but, in some studies, about 40 percent had a recurrence of headache within 24 hours. This might be explained by the short duration of action of the drug. In these situations a second 6-mg injection may be administered, at least one hour after the first injection. The maximum recommended dose that may be given in a 24-hour period is two 6-mg injections.

Imitrex injection is supplied in a solution for subcutaneous injection that contains 6 mg of sumatriptan (base) as the succinate salt in each 0.5 ml. The available formulations include 6-mg single-dose vials; unit-of-use syringes in cartons of two syringes; and an Imitrex SELFdose system kit that contains two unit-of-use syringes, one Imitrex SELFdose unit, and instructions for use. In addition to the written instructions, a videotape which demonstrates the use of the auto-injector unit is available to facilitate patient understanding of the injection technique.

A tablet dosage form of sumatriptan is available in certain other countries, but has not yet been approved for marketing in the U.S. When administered orally, sumatriptan has a slower onset of action and may be less effective than when it is administered subcutaneously.

Dr. Hussar is Remington professor of pharmacy at the Philadelphia College of Pharmacy and Science.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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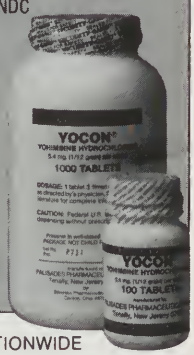

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Cancer Pain Guidelines Designed to Change Attitudes

J. Jarrett Clinton, MD, MPH

Millions of Americans suffer needlessly from the pain associated with cancer—both from growth of the tumor or tumors within the body, and from various treatment procedures, such as chemotherapy and surgery, to control the cancer. A clinical practice guideline released in March by the Agency for Health Care Policy and Research says most suffering could be avoided if cancer pain were treated more aggressively.

The Agency for Health Care Policy and Research (AHCPR) expects its newest practice guideline on controlling cancer pain will be useful to practitioners working closely with cancer patients. More than eight million Americans today live with cancer or have had cancer; another 1.2 million cases will be diagnosed this year.

The clinical practice guideline can be implemented by health care professionals at a community hospital, a nursing home, or in a family practice as easily as it can by a team of oncologists at a major research center, according to Barbara S. Shapiro, MD , assistant professor of pediatrics, University of Pennsylvania School of Medicine, who helped draft the document.

She and other panel members—drawn from diverse backgrounds, including oncologists, anesthesiologists, neurologists, family practitioners, surgeons, psychiatrists, psychologists, religious leaders, and cancer patients—spent more than two years examining 9,600 published sources and consulting 500 other pain experts before writing the guideline.

Before being released, guidelines are peer-reviewed and pilot tested. This is the ninth of 10 guidelines AHCPR, a component of the U.S. Public Health Service, has published since 1992.

Dr. Clinton is administrator, Agency for Health Care Policy and Research, Bethesda, Maryland.

Cancer guideline findings

The new AHCPR-supported guideline challenges several assumptions that have hindered effective pain control. The most pervasive is the unfounded belief that giving patients opioid drugs used to fight pain leads to addiction. This assumption is especially strong when treating minorities, who are wrongly suspected of being more susceptible to addiction. Another assumption is that children and the elderly are less sensitive to pain than other age groups.

Patients' attitudes toward pain have also hindered their own comfort. The guideline shows that patients often believe that reporting pain is a sign of weakness, that experiencing pain—even severe pain—is an inevitable result of cancer, that pain medications taken too soon in the treatment process will not work later when pain is more severe, and that reporting pain to a practitioner will prompt him or her to treat the pain and neglect the cancer that causes it.

The guideline recommends that practitioners provide patients with easy-to-use diagrams of the body on which they can point to areas where pain occurs. It also includes a vocabulary of pain terms to describe the various types of pain, such as burning or stinging, that can occur with cancer and its treatment forms.

A major step forward is the recommendation that hospitals, nursing homes, and other facilities form interdisciplinary pain management teams to develop pain management protocols, formulate individual pain management plans, and educate patients and their families about pain and how to relieve it.

Fox Chase Cancer Society

Adapting guidelines to a local setting is an effective method of implementation. Although AHCPR-sponsored guidelines are science-based and prepared by a multidisciplinary panel of experts, they are flexible documents that make allowance for legitimate differences of clinical opinion.

An overriding strength of the AHCPR-supported guidelines is the effect of the input of physicians, as panel members. Michael H. Levy, MD, PhD, director of the Pain Management Center at Fox Chase

Cancer Center, Philadelphia, is among those recognizing that the key to implementing guidelines from any source is to include practitioners in their preparation.

Dr. Levy and Gerald E. Hanks, MD, chairman of radiation therapy at Fox Chase, peer-reviewed an early draft of the guideline more than a year ago. Panel members spent two-and-a-half years preparing the guideline, starting with a comprehensive review of the professional literature and a thorough analysis of the most reliable scientific articles. Panel members applied their expert knowledge to the draft document, then submitted it to appropriate centers for peer review.

Dr. Levy distributed the draft version to nurses, radiology oncologists, social workers, pharmacists, and others, and solicited their comments. Based on those comments and on their experiences at Fox Chase, Drs. Levy and Hanks suggested several revisions that were incorporated into the guidelines.

Children's Hospital of Philadelphia

Health care professionals, and the physician community in particular, are committed to relieving the pain that patients experience from their illness and from invasive treatments that might be needed for that condition. Despite that commitment, too often studies and clinical experience show patients still experience discomfort.

In a study by J. Bonica cited in the AHCPR-supported cancer pain guideline, nearly 75 percent of patients with advanced cancer have pain. Half of those patients experiencing pain say it is moderate to severe, and one of every four patients who experience pain describe it as being very severe.

Ironically, as Dr. Shapiro notes, the prevalence of pain can actually slip through the diagnosis as health care providers, anxious to treat the condition that led the patient to seek help, rely more heavily on advanced technology and a biomedical model of treatment, losing touch with the human dimension of the frightened patient.

Dr. Shapiro, who also serves as associate director of pain service at Children's Hospital of Philadelphia said that medical practitioners, instead of seeing their patients as individuals, too often refer to them by condition, as "the breast cancer in Room 202"—just one more stop in a busy practitioner's crowded schedule.

The AHCPR-supported cancer pain guideline can be implemented, but may need review by state regulatory agencies that now have jurisdiction over the dispersement of opioid prescriptions. The guideline cites studies showing that the properly administered use of opioids in the treatment of cancer pain is appropriate.

Currently, many practitioners and patients carry beliefs about the addictive nature of these natural pain killers that are not correct.

The guideline as resource

William Breitbart, MD, a panel member and psycho-oncologist, said he uses the AHCPR-supported guideline as a teaching tool at Cornell University Medical College, where he teaches psychiatry. Dr. Breitbart also directs a continuing quality improvement program at Memorial Sloan-Kettering Cancer Center in New York City that is partially financed through a grant from the National Cancer Institute. The quality improvement program, which is repeated →

Pain Management Strategies: A Hierarchy

Consultants' estimates of prevalence of use of progressively more invasive therapies

- Nerve blocks, palliative surgery, and ablative surgery, 1–5%.[1]
- Epidural and intrathecal analgesics, 2–6%.[2]
- Intravenous and subcutaneous drugs, 5–20%.[3]
- Oral, transdermal, and rectal drugs, 75–85%.[4]

1. Hiraga, Mizuguchi, and Takeda, 1991; Portenoy, 1993; Ventafridda, Caraceni, and Gamba, 1990.
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3. Keller, 1984; Paice, 1993; Portenoy, 1993.
4. Goisis, Gorini, Ratti, et al., 1989; Hiraga, Mizuguchi, and Takeda, 1991; Scug, Zech, and Dörr, 1990; Takeda, 1986; Ventafridda, Caraceni, and Gamba, 1990; Walker, Hoskin, Hanks, et al., 1988.

Note: The pyramid depicts a hierarchy of pain management strategies from least invasive (at the base) to most invasive (at the apex). Therapies depicted on the ribbon may benefit many patients who are receiving concurrent treatments at any level of invasiveness. Estimates presented in this sidebar are based on published data and consultants' estimates for various clinical populations in industrialized nations, but may not reflect all settings and do not necessarily reflect what is optimal.

in other institutions across the country, identifies the health professional at the community level—whether a nurse, oncologist, anesthesiologist, or other is responsible for teaching pain management techniques at their home institution. Those professionals are invited to the cancer center to observe its pain management program, use its resource center and library, and continue a mentoring relationship in which the professional staff help them design symposia, conduct research, or perform other outreach activity.

Until the cancer pain guideline was published, Dr. Breitbart said he used the AHCPR-sponsored acute pain management guideline, developed by many of the same panel members, as a resource.

To obtain free copies of *Management of Cancer Pain,* Clinical Practice Guideline Number 9 (257 pp.); *Management of Cancer Pain: Adults,* Quick Reference Guide for Clinicians, Number 9 (28 pp.); *Managing Cancer Pain: Infants, Children, and Adolescents,* Quick Reference Guide for Clinicians Number 9 (28 pp.), and *Managing Cancer Pain: Patient Guide* (21 pp., in Spanish as well), call (800) 358-9295, or write to: AHCPR Clearinghouse, Cancer Pain Guideline, P.O. Box 8547, Silver Spring, MD 20907. The quick reference guide, patient guide, and a five-page overview of the guideline are also available from AHCPR Instant Fax. Call (301) 594-2800 from a telephone-equipped facsimile machine.

Conclusion

Perhaps no factor is more important in creating improvements to the health care system than developing more reliable information on the best ways to manage specific diseases and conditions. AHCPR works toward that end by sponsoring the development of guidelines. As medical knowledge advances and new technologies are developed, the guidelines are updated. ○

Practice Parameters: Key To Future Reform

The medical profession has a long history of leadership in a wide array of activities to ensure quality, appropriate, and necessary medical care. With strong empirical evidence indicating the use of practice parameters can improve the quality of medical care and facilitate appropriate utilization of health care services, the American Medical Association (AMA), in conjunction with numerous medical specialty and state medical societies, the federal government, and other groups, is actively involved in the development, evaluation, dissemination, and implementation of practice parameters. Increasingly, physician and nonphysician organizations are working cooperatively in the rapidly evolving practice parameters arena.

Overview of activities

Consistent with its broad commitment to promote quality medical care, in 1989 the AMA established two working groups of national medical specialty and state medical societies to address the development of practice parameters by physician organizations.

The *Practice Parameters Partnership* is a cooperative activity created to guide and coordinate the activities of the medical profession in the development, evaluation, dissemination, and implementation of practice parameters. Members include the AMA, 14 national medical specialty societies, the Agency for Health Care Policy and Research, the American Hospital Association, and the Joint Commission on Accreditation of Healthcare Organizations.

Since its establishment, the partnership has been responsible for the adoption and implementation of numerous resolutions that have advanced the development, evaluation, dissemination, and appropriate implementation of scientifically sound, clinically relevant parameters.

The *Practice Parameters Forum* provides the scientific expertise and broad-based clinical representation necessary to ensure the development of scientifically sound, clinically relevant practice parameters and the conduct of valid and reliable outcomes studies. The forum has active participants from more than 80 medical specialty and state medical societies and other interested organizations.

Development

Since 1989, when the AMA first published its *Directory of Practice Parameters,* which identified more than 700 parameters, almost 1,500 practice parameters developed by more than 45 physician organizations and other groups have been identified.

In addition, there are more than 200 practice parameters currently under development by physician organizations and other groups.

Benefits

As illustrated by the following example, both physicians and patients have benefited from the development and implementation of practice parameters:

- Practice parameters for performance of cesarean section (C-section) have resulted in a decrease in C-section rates, with no increase in fetal or maternal morbidity or mortality.
- Practice parameters on proper timing of prophylactic antibiotic administration have been correlated with a 50 percent decline in incidence of deep postoperative wound infections.
- Practice parameters for monitoring patients during general anesthesia have resulted in a marked reduction in the incidence of hypoxic injuries.
- Practice parameters for cardiac pacemakers have resulted in a significant decline in pacemaker utilization rates.
- Practice parameters for transfer of cardiac patients from coronary care units (CCUs) have improved the utilization of CCUs.

Conclusion

There is growing recognition that practice parameters provide a promising mechanism to rationalize clinical practice. At both the federal and the state level, practice parameters and related quality assurance mechanisms are key elements of legislative proposals to reform the health care system. Practice parameters are perceived as an effective mechanism to improve quality and enhance the value of health care services.

Excerpted with permission from an article by John T. Kelly, MD, PhD, and Margaret C. Toepp, PhD, in Michigan Medicine, *March 1994.*

Q&A: CLINICAL LAB OVERPAYMENTS

The State Society, working closely with the American Medical Association (AMA) has saved Pennsylvania physicians nearly $3 million in refunds demanded as a result of a payment error by Pennsylvania Blue Shield (PBS). The Society had been negotiating with PBS and the Health Care Financing Administration (HCFA) since it first learned of the Medicare clinical lab overpayment refund by PBS last August.

The Society, the AMA, and other states involved in the issue have also been working to minimize hassles in the appeals process, and the carrier handling that process has agreed to pursue joint representation of physicians for the "at fault" issue.

As information, the Society's Office of General Counsel has prepared the following questions and answers to inform affected physicians of their options and explain the Society's role. Direct any other questions to Susan M. Weber, Esq., in the Society's legal department, at (800) 228-7823 or (717) 558-7750, ext. 492.

How did the clinical lab repayment issue arise?

Pennsylvania Blue Shield, as the Medicare Carrier for this region, demanded repayment from almost 1,500 physician labs for what Blue Shield characterized as "overpayments." Blue Shield had failed to follow HCFA payment policies and had overpaid labs for certain organ panels. Physicians were outraged by the tone of the Blue Shield letter and by the demand itself. That led to a series of meetings between the Society and Blue Shield, and the Society and HCFA.

The net result was that HCFA forgave two-thirds of the overpayment amounts and eliminated more than three-fourths of the physicians from the repayment pool. Out of 1,451 physicians who allegedly owed $4,150,922 in overpayments, State Society efforts were successful in netting a reduction to 343 physicians who owe $1,384,386, as well as other concessions, such as installment arrangements for repayment and a partial waiver of interest.

How are payment disputes like this usually handled?

Normally, payment disputes are settled through an administrative process involving several levels of appeals through the carrier and HCFA, and ultimately they may reach the courts. HCFA agreed to concede two-thirds of the argument before we even reached the initial appeal level with the carrier.

What is the State Society doing to help physicians at these administrative hearings?

To the extent possible, the State Society is representing the interests of the physician group as a whole. Some physicians wanted the Society to handle the case in the name of the Pennsylvania Medical Society; we could not do so because of legal barriers that would be difficult to overcome. Other physicians suggested that the Society file a class action lawsuit. Unfortunately, administrative practice before a governmental agency such as HCFA does not include the prerogative of filing a lawsuit in the initial stages.

According to federal laws and regulations, the various appeal stages within the agency itself are prerequisites to the filing of a lawsuit in court. Generally, the appeals would be centered within the carrier who is responsible for this region. Because of PBS's involvement in this case, the Society argued to HCFA that PBS should not be the carrier under which appeals would be heard and urged HCFA to appoint a neutral carrier. HCFA agreed that Blue Cross-Blue Shield of Maryland (Md. BS) would hear the appeals. Md. BS has agreed to use a type of "consolidation" for the issues common to most of the physicians involved.

How will this consolidation work?

Because physicians from several states and the District of Columbia are involved, the AMA has retained outside counsel, the law firm of Sidley and Austin, to represent those physicians who wish to pursue their appeals through the group. This method of appeal has practical advantages, such as decreasing the total number of cases argued before the hearing officer, thereby increasing cost and time efficiencies. However, the common appeal process may not be appropriate for every physician.

What issues are common to most physicians involved?

The one issue that will be pursued through the consolidated appeal process is the position that the alleged overpayments were caused solely by PBS error. Therefore, physicians are not "at fault," and no repayment from physicians should be required. While we believe that this issue universally applies to physicians involved, some physicians may have other issues which they wish to raise. In that case, those with other issues, such as errors in calculation of the claim amounts, may wish to pursue their claims independently through personal counsel.

What are some other approaches to appeal through the carrier?

In addition to joint appeal of the "at fault" issue, and individual appeal through personal counsel, physicians may choose to file a "paper" appeal, one which is based strictly on information and arguments submitted on paper. The State Society has an affidavit and brief, prepared by Sidley and Austin, which may be used for this purpose.

What time frame should we be concerned with?

An appeal may be filed any time within six months after the date of the demand letter sent by PBS. However, physicians who would like to join in the consolidated appeal process should contact the Society's legal department as soon as possible, so that the group represented through the AMA can be identified.

Representatives from the State Society, the AMA, and other state societies were scheduled to meet with the Md. BS hearing officer on April 25 to determine an appropriate procedural approach. More information will be available from the Society's legal department as the appeals process develops.

Kenneth B. Jones, Esq., the Society's general counsel, and Susan M. Weber, Esq., assistant general counsel, contributed to this page.

Society Kicks Off Capitol Contacts Program

The State Society's Governmental Affairs Division in mid-March kicked off its Capitol Contacts Program to strengthen its grassroots lobbying efforts. The new program replaces the Society's Key Contact and LAT Team programs.

The move to the Capitol Contacts Program is the result of the Council on Governmental Relations' actions following a recommendation of a task force on grassroots lobbying, established by county medical society executives. The council and the county task force carefully studied the issue earlier this year and used their results as the basis for the new program.

According to Lawrence Altaker, MD, vice chairman of the council and program chairman, "Our goal is to get as many physicians and spouses as possible involved in grassroots lobbying, and to encourage them to develop contacts with their legislators."

Contacts will be kept up-to-date on legislative developments through mailings and Society publications, and, as needed, will be asked to talk with their legislators about specific issues. To accomplish this, they will need to develop good relationships with their legislators and become responsive to legislators' needs whenever medical questions arise—to become their "medical expert."

To help them in their efforts, the Society will supply each enrollee with a newly developed welcome packet containing program information and educational materials, including:

- a Capitol Contact manual, entitled "Making the Connection";
- a legislative directory;
- a complete list of Senate and House committees monitored by the Society; and
- pre-printed tracking forms to be completed and sent to the Society following legislative contacts.

"Calls to Action"—like those issued under the previous programs—will be used to educate participants and county medical society executives about specific legislative issues, and suggest action. The Society is also considering establishing a fax network to alert contacts of sudden legislative efforts or quickly scheduled committee meetings, and an 800-number hotline or document retrieval service for contacts to access the latest information on specific legislative issues.

Society lobbyists believe the most important change, from the former program to the new, is the use of a database to target contact groups according to specialty, region, or issue. For example, in the past the Society would "call" *all* key contacts to action; on any particular targetted issue before the House Health and Welfare Committee, committee members might receive hundreds of letters from key contacts statewide. Under the new program, 30 or 40 contacts acquainted with committee members might be asked to write letters supporting the Society's position.

Dr. Altaker explains: "It's been our experience that legislators prefer to hear from their own constituents regarding issues that are important to them, as well as possible actions and solutions. Thus, we believe *streamlining* our message will prove more efficient and effective."

The Society anticipates these changes will encourage more physicians to become involved in grassroots lobbying efforts; the overall program is designed to steer those physicians in the right direction.

Solicitation for the program began in March and will continue in "waves." Dr. Altaker says he is encouraged by the initial response—more than 250 enrollments in the first few weeks following solicitation—and hopes to build on that.

For more information about the Capitol Contacts Program, call the Society at (800) 228-7823 or (717) 558-7750.

New Legislation

Senate Bill 1525, "Any Willing Provider"

Senator Raphael J. Musto (D-Luzerne) has introduced Senate Bill 1525, which requires an HMO to accept "any willing provider" who meets quality standards. The bill has been referred to the Senate Public Health and Welfare Committee; consideration is expected in the near future as part of health system reform.

House Bill 2456, HIV Testing

Representative Tom Stish (D-Luzerne) has introduced House Bill 2456, which authorizes physicians to test any patient for HIV on the basis of clinical judgment and requires reporting HIV "as any other communicable disease." The bill has been referred to the House Health and Welfare Committee.

PROVIDERS REMINDED TO MAINTAIN TAIL COVERAGE

A recent letter from the director of the state's Medical Professional Liability Catastrophe Loss Fund (CAT Fund) reminds providers that state law requires physicians to maintain "tail coverage" as part of their CAT Fund participation.

The purchase of tail coverage after the termination of a claims-made policy and the payment of the surcharge are mandatory insurance requirements of the Health Care Services Malpractice Act of 1975 (Act 111).

According to the CAT Fund, failure to satisfy this obligation will require the fund to disclaim coverage for all claims reported subsequent to the termination of the policy, and to notify state licensing authorities of a health care provider's non-compliance with Act 111. This may result in license suspension or revocation in Pennsylvania.

For further information, call the CAT Fund at (717) 783-3770.

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ACTIONS OF THE BOARD OF TRUSTEES, MARCH 9, 1994

BOARD APPROVES INCORPORATION OF NEW SUBSIDIARY

The State Society's Board of Trustees at its March meeting formally approved the mission statement and filing of articles of incorporation of a new for-profit subsidiary, PennMed Member Services Company (PMSCO), to provide practical, physician-directed consulting and practice management services to physicians. The action follows extended study by the board.

Mission

PMSCO's mission is to advocate physician interests by initially providing: 1) consultative services for the establishment and management of physician-controlled multispecialty networks and related entities; and 2) appropriate support services and products. This includes the development of physician-led and, preferably, physician-controlled networks that could solicit and successfully negotiate contracts with health care purchasers.

As shown in the chart (below, at right), PMSCO is organizationally equivalent to the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) and the Keystone Peer Review Organization (KePRO). The new subsidiary will be located at Society headquarters in Harrisburg along with existing subsidiaries, and will include two components: a management services organization (MSO) and physician services.

Range of services

For PMSCO to enable physicians to participate in the health care delivery system as the Society intends, several very sophisticated services must be provided, including three categories of consulting services under its MSO:

- *Network consulting* services will include strategic planning; business plan development; practice valuation/buy-in arrangements; capital acquisition; linking physician organizations (POs), physician-hospital organizations (PHOs), and independent practice associations (IPAs); actuarial services; and management information systems (MIS) development and evaluation.
- *Practice management consulting* services will include billing and collection consultation; general reimbursement consultation; employee benefit selection; education and training (to be done cooperatively with the State Society); risk management (to be done cooperatively with PMSLIC); group purchasing (to be done cooperatively with PMSLIC, the Society, and others); and third-party administration/claims processing consultation.
- *Data management consulting* services will include application of clinical protocols and related data analysis; utilization review data collection/consultation; application of outcomes measurement system and related data analysis; and physician/office staff education (to be done cooperatively with the State Society).

Also, PMSCO will serve as the liaison between networks and other service providers. An important extension of this function will be soliciting business from health care purchasers on behalf of physician-led integrated delivery systems.

PMSCO will also initiate and/or participate in educational symposiums and seminars that address issues related to its services, as well as in cooperative ventures with the State Society, PMSLIC, KePRO, and other subsidiaries that may be established. This effort will combine the strengths and resources of these organizations.

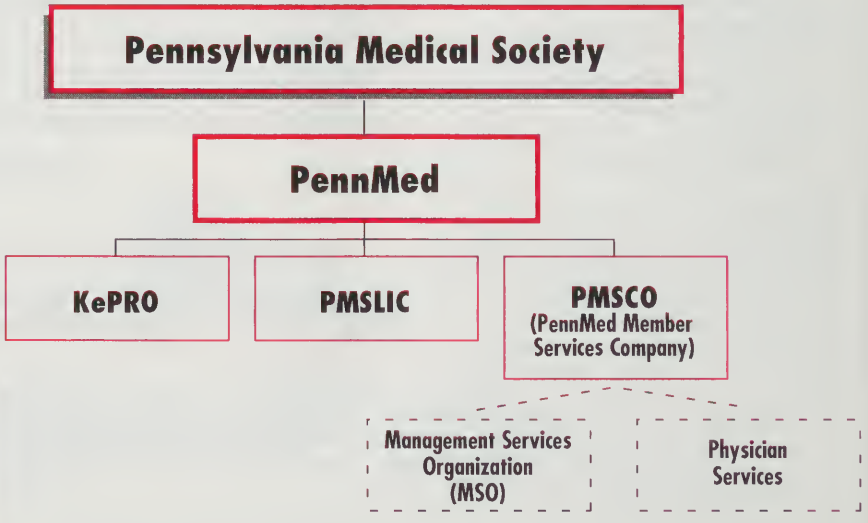
Specialty societies were represented in the development of the MSO through a special task force established by the Interspecialty Section. Continued specialty society involvement will be important for the MSO to be successful.

Once the MSO line of business is implemented, the physician services component will be developed to include some existing, as well as new, Society programs and services. Transfer of existing programs and services will occur according to guidelines determined by the board. In the meantime, the board has authorized the Council on Medical Practice to continue to manage all existing Society offerings.

PMSCO's future

In other action, the board authorized $1.2 million to capitalize and operate PMSCO though 1996. Sources of this funding include transfer of funds previously authorized for related services; solicitation of funding from specialty societies, related organizations, and individual physicians; and short-term, in-kind Society contributions in the form of temporary reallocation of selected staff and reduction, if necessary, of existing programs.

Consulting services are already available from the State Society's newest subsidiary. To inquire about PMSCO services, call the Society at (800) 228-7823.



MEDICAID PRIMARY CARE INITIATIVES REVIEWED

The board reviewed the most current information on the Department of Public Welfare's (DPW's) Primary Care Case Management Initiatives for Pennsylvania's Medical Assistance (MA) population. The three plans discussed were: HealthChoices, the Lancaster Community Health Plan, and the Family Care Network.

HealthChoices, which has been approved by the Health Care Financing Administration (HCFA), would provide more than 650,000 MA recipients in Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia counties with primary and other health care services through a network of managed care organizations (MCOs). The proposal divides the six counties into three zones and would contract with at least two MCOs to operate in each zone. Each recipient will be required to enroll in one of the offered MCOs, and primary care practitioners will deliver primary care and serve as gatekeepers for other services.

The program is expected to begin November 1, 1994. The Society—concerned about the zone divisions, physician selection criteria, and patients' lack of choice of providers—will monitor the MCO bidding process, now in progress.

The *Lancaster Community Health Plan (LCHP)* will link each participating MA recipient in Lancaster County with a source of primary medical care. Patients select the caregiver of their choice, and that caregiver is responsible for providing access to care for clients on a 24-hour basis and for making all non-emergency referrals to hospital and specialty care. Reimbursement is proposed at current rates, to be paid by DPW, plus a per patient/per month case management fee.

LCHP recently received waiver approval from HCFA and will now proceed to finalize a contract with DPW for operation of the plan. Implementation is expected by July. The Society will help promote the program statewide and continue to follow its development.

The *Family Care Network (FCN)* intends to establish a primary care case management program for MA recipients under 21 years old in the 60 counties not covered by the other two plans. Like the Philadelphia plan, FCN would attempt to link each recipient with an enrolled primary care provider. Unlike the Philadelphia plan, the recipient would have a choice of primary care providers, not of plans. The reimbursement system resembles that of the Lancaster plan.

Recruitment of providers has begun in York, Erie, Westmoreland, and Washington counties; the ultimate goal is to have the 400,000 eligible recipients in the 60 counties enrolled with a primary care provider by July 1995. The Society has participated in recruitment efforts and recommended changes and modifications to the plan, many of which have been accepted. (See the next issue of PENNSYLVANIA MEDICINE for a complete overview of these programs.)

SOCIETY SUPPORTING ANTI-TOBACCO EFFORTS

At the recommendation of the Council on Education and Science, the Society is prepared to donate $5,000 a year for four years to support an anti-tobacco grant of the Coalition for a Tobacco-Free Pennsylvania. The grant application is currently under review.

The Society is a long-standing member of the coalition, which has submitted a proposal to the Robert Wood Johnson Foundation (RWJF) for a grant under its Smokeless States Initiative. The grant would provide matching funds to any state able to develop an anti-tobacco coalition to create and implement comprehensive tobacco control programs statewide that include education, treatment, and policy initiatives. A total of eight states will be selected to receive up to $1.2 million in matching funds over four years.

The coalition asked each of its members for a financial or in-kind donation toward satisfying RWJF requirements, and the Society's board agreed to the donation, as well as providing accounting services to manage the anticipated grant and matching funds.

INCREASE PROPOSED TO CAT FUND PRIMARY LIMITS

The Catastrophe Loss Fund (CAT Fund) is supporting an increase in the malpractice insurance limits for primary insurance from $200,000 to $500,000. Total mandated insurance coverage would thus increase from $1.2 million to $1.5 million per occurrence.

CAT Fund Director Thomas P. Callahan attributes the need for an increase to inflation in the size of the average award, but stresses that the primary limits have not been raised since 1984. The Society traditionally opposes such increases since increased malpractice limits translate to increased malpractice premiums/surcharge.

Amendment of the Health Care Services Malpractice Act (Act 111 of 1975) is required to increase the limits.

PETITION ASKS FOR MORE LENIENT GUIDELINES

The Society, at the direction of the board, will petition the State Board of Nursing to modify the intravenous conscious sedation guidelines regarding the requirement for advanced cardiac life support (ACLS) training for registered nurses giving conscious sedation or monitoring patients who have received conscious sedation.

The Society proposes that the RN only be required to have basic life support (BLS) competence, if the facility where conscious sedation is given has a resuscitation team with ACLS compatibility, and the resuscitation team can be in the room where conscious sedation is being given within four minutes. BLS competence only would be required if an ACLS-certified professional (physician or nurse) is a member of the team treating the patient and is immediately available. Otherwise, the RN must have ACLS training.

The recommendation comes from the Interspecialty Section, which believes that requiring all RNs to be ACLS certified—as the guidelines currently state—is redundant, costly, and does not add to patient safety or care when a code team is available.

HOUSE TO CONSIDER NEW DUES BILLING SYSTEM

In other action in March, the board directed the Society's Committee on Bylaws to develop appropriate bylaws for consideration by the 1994 House of Delegates to implement a new dues billing system, to bill each member in the month they joined the Society.

Further, the board directed the committee to prepare appropriate bylaws language to elimiminate references to dues categories in the bylaws.

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Voices of the Future

Maria T. Montesano
Assistant Managing Editor

This final of three articles profiling the State Society's newly elected trustees features Joyann A. Kroser, MD, Resident Physician Section, and Stacy L. Krisher, Medical Student Section.

"The basic challenges of reform are: How do we get the most efficient care to the people who need it most, and how do we do it in such a way that both providers and patients come out winners?"

—Joyann A. Kroser, MD

The term, "the uncertainty of the future of medicine" is almost cliché with regard to health system reform; yet, it seems to be the reality of medicine's future—especially for residents and students who have chosen medicine, knowing full well that the profession they train for today could easily change tomorrow.

The State Society almost a decade ago allotted two positions on the Board of Trustees—one to the Resident Physician Section (RPS) and one to the Medical Student Section (MSS). At that time, the Society may not have realized what an important move it was, but as the reality of reform slowly approaches, these positions become even more vital—as a forum for the voices of the future.

The voice of residents

Joyann A. Kroser, MD, RPS trustee, grew up in medicine—her parents, both family practitioners, practiced out of their Philadelphia home. She says instead of watching cartoons after school, she and her siblings would "run around" the office. "In the beginning, I helped the receptionist and nurses, but eventually I worked my way up to helping my dad and mom with patients...It truly was a family practice." That childhood led her to medicine: "I couldn't picture myself doing anything else," she says.

Dr. Kroser participated in a six-year MD program offered through Lehigh University and the Medical College of Pennsylvania (MCP). She received her medical degree in 1990 and is currently completing her chief residency year in internal medicine at MCP. In July, she will begin a gastroenterology fellowship at the Hospital of the University of Pennsylvania.

One of her most interesting training experiences, she says, was serving a national health policy fellowship with the U.S. Department of Health and Human Services. She worked mostly with intradepartmental affairs and says, "Overall, the experience was an introduction to how the organization of medicine interfaces with the government. It really sparked my interest in organized medicine."

She also credits her mother, Lila, with reinforcing her interest in the Society. "My mother was a good role model to follow. She has been active in the Society for a long time, [and] participation just seemed natural for me...to express an opinion and make sure things get done." As a trustee, she represents resident interests to the board, and reports activities and decisions back to the RPS Governing Council.

One of the "hot" topics during recent Society board discussion remains health sys-

Dr. Kroser

"If you're going to change the way we deliver health care, then you also, fundamentally, must change the way we educate and train physicians."

tem reform—"a complicated issue," according to Dr. Kroser. "A sense of urgency has come up this year, which is probably accurate...The basic challenges of reform are: How do we get the most efficient care to the people who need it most, and how do we do it in such a way that both providers and patients come out winners?"

She says residents must be involved in the discussions because reform will definitely affect how they practice medicine and their long-term futures. She also believes universal access is an important reform issue for residents, since they, at this point in their training, see access problems "day in and day out," and "are keenly aware of the problems related to access."

Ms. Krisher

"Everything is changing, and what's happening now will determine our future."

Though she realizes reform will include a lot of "give-and-take," she strongly contends, "If you're going to change the way we deliver health care, then you also, fundamentally, must change the way we educate and train physicians. For instance, if we want more primary care physicians, then we must find ways to train them better and offer more incentives than just financial ones."

Still, she says, "What is most important at this point is to be involved and make residents' concerns known," a task she is not taking lightly in her trustee role.

The voice of students

Stacy L. Krisher, a Bucks County native, credits her family doctor for her decision to enter the medical field—she spent her eighth grade career day following him around his office.

A graduate of Texas A&M with a degree in bioengineering, and a second year medical student at the University of Pittsburgh, she was elected MSS trustee at the annual meeting last October.

She joined organized medicine in 1992 as a first-year medical student, and though she is not a voting member of the board, she sees her trustee position as "an opportunity to learn more about how the system works and to have some say in what medical students get out of the system." She says, "It's interesting to see what the Society does and how those actions will affect our futures."

One major student concern regarding reform, according to Krisher, is what effect health system changes will have on the doctor-patient relationship. "Will we be able to see the same patient over and over again, and actually develop a relationship?" she asks. "Or, will it be like the Medicaid system is now, where patients see whatever doctor is available at the time?"

She echoes residents' calls for universal access, as well: "Students are definitely for universal coverage. We are worried about what kind of situation we'll be working under and what quotas may be instituted." And she says students continue to worry about the debts they are incurring for medical school.

There is no crystal ball for medicine's future, which is why Krisher encourages students to become involved in the issues. "Student membership has fallen off in the past year, but this is a very important time for students to be more involved. Everything is changing, and what's happening now will determine our future."

As for her own future, Krisher is leaning towards a primary care specialty—perhaps internal or general medicine—though she says it's hard to say what type of medicine she'll be practicing down the road: "I'm trying not to limit myself. When I get into the clinical training, then I'll start narrowing down my choices."

But again she turns to the uncertainty of the future: "I don't think you ever know for sure what you want to practice before you start your clinical years; but it's especially difficult to know now, with the uncertainty of health system reform." ⬡

"[Students] are worried about what kind of situation we'll be working under and what quotas may be instituted."

—Stacy L. Krisher

Project Seeks to Bolster Immunizations

The State Society is working with the Pennsylvania Chapter of the American Academy of Pediatrics and the state Department of Health to bolster immunizations in the state through the Pennsylvania Statewide Immunization Information System Project.

The goal of the program is to develop a system that will:

- ensure the adequate vaccination of at least 90 percent of all children born on or after October 1, 1995;
- ensure the follow-up of children who miss scheduled vaccinations;
- ensure confidentiality while enabling appropriate health care providers to access a child's vaccination status;
- monitor adverse reactions to immunizing agents; and
- monitor vaccine distribution and usage.

For its part, the Pennsylvania Chapter of the Academy of Pediatrics is developing the immunization tracking program—a centralized database of children's immunization records. Funding for the program was received earlier this year through a federal grant to the state Department of Health.

The Society, as well as serving on the advisory board of the tracking project, has agreed to work with medical schools to ensure that the most current immunization practices are being taught. The thinking is: In order for the system to work, physicians must cooperate by keeping records current. While the Society will seek the least burdensome way to accomplish this, it also realizes that teaching future physicians about the immunization project will have a great impact on cooperation later on.

Our initial step will be to study what is being taught about immunizations in medical schools. Funding for our study—to be developed by the Society's Educational and Scientific Trust—is expected early next year.

Currently, the project's task force is studying similar programs in place in other states.

PHYSICIANS REMINDED OF TB REPORTING REQUIREMENT

The Centers for Disease Control and Prevention (CDC) remind Pennsylvania physicians that they are required by law to report confirmed and suspected cases of tuberculosis to the state, and that physicians not complying are subject to penalty for failure to report.

According to the Pennsylvania Department of Health TB Control Program, such cases should be reported "promptly" to your local state health center, or county or municipal health department, by completing a Case Report or calling your health center or department.

Pennsylvania currently has nine county and municipal health departments: Allegheny County Health Department, Allentown Bureau of Health, Bethlehem Bureau of Health, Bucks County Department of Health, Chester County Health Department, Erie County Department of Health, Montgomery County Health Department, Philadelphia Department of Public Health, and York City Bureau of Health.

Physicians in the counties and cities listed above should report cases of tuberculosis to these agencies. If your county or municipality is not listed, you should report to your local state health center.

The CDC also recommends:

- When a case of TB is identified as being drug resistant, it should be reported *again* to your health center or department. The report should include the results of susceptibility testing.
- TB patients who have demonstrated an inability or unwillingness to adhere to a prescribed treatment regimen should be classified as "nonadherent," and any health care professional who is aware of such a case should contact the local health center or department for necessary intervention.

Physicians are also advised that most health departments offer a number of related services to control TB in Pennsylvania such as:

- directly observed therapy, or DOT, defined at "treatment in which health care providers or other designated persons observe patients ingesting anti-TB medications";
- free medications to patients who cannot pay for them;
- diagnostic services;
- contact evaluation; and
- medical consultation.

For more information on state reporting requirements for TB, call the TB Control Program of the Pennsylvania Department of Health at (717) 787-6267. Addresses and phone numbers for local health departments and state health centers are listed in the blue pages of your telephone book.

Sources:

1. TB Control Program, Pennsylvania Department of Health.
2. Centers for Disease Control and Prevention. Tuberculosis control laws—United States, 1993; recommendations of the Advisory Council for the Elimination of Tuberculosis (ACET). *MMWR* 42(RR-15), 1993.

AZT REDUCES MATERNAL TRANSMISSION OF HIV

Zidovudine (AZT) therapy has reduced by two-thirds the risk of transmission of virus from HIV-infected pregnant women to their babies, according to preliminary results of a trial sponsored by the National Institute of Allergy and Infectious Diseases (NIAID), in collaboration with related organizations worldwide.

An interim review of the study revealed a transmission rate of 8.3 percent when both mothers and their babies received AZT, in comparison with a transmission rate of 25.5 percent among those receiving a placebo.

"Although this treatment did not protect all the babies in the study, the news that the risk of HIV transmission to newborns can be significantly reduced is very promising," says Donna Shalala, secretary of the U.S. Department of Health and Human Services.

The study investigators plan to follow the infants for a number of years because the long-term

consequences of AZT therapy are unknown. Also, they will follow the women in the trial for six months after delivery. No recommendations about treatment to prevent transmission of HIV during pregnancy and delivery are being made at this time.

FDA ANNOUNCES RECALL OF LIQUID ANTIBIOTICS

The Food and Drug Administration (FDA) has announced a recall by Eli Lilly of the liquid oral antibiotics Ceclor, Lorabid, and Keflex, because several containers have been found to contain a foreign object. Consumers have been advised to stop using these products and consult a health care professional. The object—a small plastic cap found in four of the containers—could cause choking.

If a therapeutic alternative is not readily available or appropriate, patients or the physician are advised to carefully check the medicine prior to administering to ensure that it does not contain a plastic cap.

The company is recalling the products voluntarily. The FDA is investigating this matter in cooperation with other authorities. Anyone who has found a foreign object in these products should contact Eli Lilly at (800) 545-5927.

Ceclor, Lorabid, and Keflex are sold to pharmacies in powdered form and reconstituted before being dispensed to consumers. There is no known risk to patients who have completed therapy with Ceclor, Lorabid, or Keflex.

AMA OPPOSING MINORITY HEALTH IMPROVEMENT ACT

The AMA Medical Student Section (AMA-MSS) has called on its members to contact their representatives in Congress and express opposition to HR 3869, the Minority Health Improvement Act. A letter to Congress from AMA Executive Vice President James S. Todd, MD, also urges rejection of the legislation, warning that it would limit the availability of federal scholarship funds to disadvantaged students pursuing primary care specialties.

The AMA-MSS is "strongly opposed to a primary care linkage to need-based financial aid." It explains that the legislation would combine three existing scholarship programs and limit the availability of scholarship funds to disadvantaged students pursuing a primary care specialty. "Positive incentives to enter a primary care specialty should be available to all medical students regardless of their financial situation," the section says.

Dr. Todd adds, "The specter of a future corps of physicians where economic factors virtually dictate career or specialty choice is abhorrent. This virtually would assure that only those who are in a financially secure position and do not need to go into massive debt to obtain a medical education will be able to have true career choice. Students from all walks of life should have the full range of options."

AGING AFFECTS HEALTH EXPENDITURE GROWTH

Editor's Note: This is excerpted from the article, "The Effects of Population Aging on U.S. Health Expenditure Growth," which appeared on the AMA Electronic Network, April 12, 1994.

According to conventional wisdom, the aging of the U.S. population is one of the major forces behind the rapid growth of national health expenditures. This seems to be easily inferred from a number of well-known facts. The elderly consume four times the amount of medical care as those below age 65.[1] The 65 and older population has been and will continue to grow at an increasing rate, and the percentage of the population at least 75 years old will continue to increase at a rate above 30 percent per year.

Nonetheless, recent studies show that the aging of the population makes a relatively small contribution to the growth in overall health expenditures.

Newhouse considered the various factors that might have caused the growth of health expenditures of the last 50 years.[2] He estimated that aging was responsible for only about 15 percentage points of the more than 400 percent increase in real per capita expenditures that occurred between 1950 and 1987. He concluded that aging could account for only a tiny fraction of the increase in expenditure and was relatively unimportant compared with other factors, especially the growth of medical technology.

Mendelson and Schwartz estimated the contribution of population growth and aging to increases in personal health care costs over various segments of the period 1975 to 1990 and for the projection period 1990 to 2005.[3]

Their findings generally agree with those of Newhouse, indicating that the aging of the population is responsible for only a relatively small proportion of the historical increase in expenditures. In the most recent period (1985 to 1990), they estimated the contribution of aging to health care costs to be 0.33 percent per year for physician expenditures, 0.39 percent per year for hospital expenditures, 1.42 percent for nursing home expenditures, and 0.45 percent for other personal health care expenditures, compared with total annual increases in real spending of 7.0 percent for physician care, 6.1 percent for hospital care, 6.5 percent for long-term care, and 7.5 percent for other personal care.

In projecting national health care expenditures based on available research, the U.S. Congressional Budget Office summarizes the effect of demographic changes: Shifts in the size and composition of the population, including the increase in the proportion of the elderly, will add only modestly to the growth of health spending over the next decade.

Population growth alone accounts for 0.8 percentage points per year of the 9.8 percent average annual growth in personal health spending between 1992 and 2000. Although older people use a disproportionate amount of health care services, the aging character of the population adds an average increase of only about 0.5 percentage points a year to the growth of personal health spending.[4]

Population dynamics often move at a much slower pace than changes in the U.S. economy. Although the aging of the U.S. population will increase health care costs, the amount of this increase will be relatively small in comparison with the large increases forecast for health care expenditures.

However, it is important to note that long-term care expenditures are more strongly affected by population aging than are other health care categories. In addition, the contribution of aging to health expenditures will increase significantly after 2005, when the baby boom generation first comes of retirement age.

References available upon request.

Foreign Service—Help for the Third World

Gwendolyn L. Schultz

Robert W. Ford, MD, chairman of obstetrics and gynecology at North Hills Passavant Hospital, Pittsburgh, is the impetus behind the formation of the World Health Mission, a nonprofit, non-religious organization which provides medical aid to Third World nations through donations and support of corporations, hospitals, and physicians.

Robert W. Ford, MD, had always wanted to do volunteer work abroad. Six years ago, he joined with Dr. Olu Sangodei, chief of surgery at North Hills Passavant Hospital and a native of Nigeria, to form the World Health Mission. For the past three years, they have furnished free medical assistance to an area of Nigeria plagued with poverty, disease, and limited medical technology.

The beginning

After its incorporation, the World Health Mission sought a Nigerian hospital which would invite them to come to their country. As Dr. Ford explains, "We wrote to 10 different hospitals [in Nigeria] asking if they were interested in having some Americans do some work there. We received 10 replies and decided to go to a hospital that was in between a hospital we would have in the U.S. and a 'bush hospital' where there was no electricity." They ended up in Jos University Hospital, a government teaching hospital located in the Jos Plateau in central Nigeria. Dr. Sangodei knew of the area and felt it would be appropriate for their mission.

Communicating for over a year with Dr. John Momoh, the chief medical officer at the hospital, Dr. Ford evaluated the number of personnel and type of equipment needed for their first mission. The Nigerian hospital receives government funding only for employee salaries. Dr. Ford says, "The government does not provide for any consumables such as sutures, gauze, or operating room equipment. Personnel are forced to go out into the world market, basically on their own, and purchase materials and equipment with the fees they charge patients."

The mission's first trip to Nigeria, in 1990, was to "an area we had only seen on *National Geographic*," Dr. Ford explains. Six health care professionals made the first trip: Drs. Ford and Sangodei, a radiologist, a urologist, a nurse anesthetist, and a scrub nurse. They paid their own expenses (roughly $2,000 per person) and brought donated medical equipment from local hospitals and organizations.

Upon arrival, they were informed that they were the first Americans to visit the hospital. Dr. Ford says, "In fact, the physicians there were surprised that a group would come from anywhere overseas. To this day I am sure they are amazed at how we ever found them... they are so isolated."

Since their first mission, representatives of the World Health Mission have made two more trips to Nigeria—in November 1991 and January 1993. A fourth trip, planned for early 1994, was postponed due to civil unrest in Nigeria.

Each trip lasts approximately 15 days. During that time, the team works from sunup to sundown, training physicians and residents, performing lectures, and operating on problems and confronting diseases not commonly found in the U.S., such as malaria, cerebrospinal meningitis, and pulmonary tuberculosis.

Providing for the needs

The physicians in the Jos hospital speak English and are well-trained. Before the mission's visits, the Nigerian physicians relied on physical diagnosis because they lacked the technology to do any other type of examination.

"They knew about the available equipment, but they could not afford it," Dr. Ford explains. "The machines they had were probably out of the middle '40s or early '50s...Most patients went into surgery without preoperative testing."

"There were no X-rays, CAT scans, or MRIs," he adds. "If you had a mass, pain, or abnormality picked up by physical di-

Ms. Schultz is the assistant director of marketing and development for the Society's Educational and Scientific Trust. This article is one in a series sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

agnosis, you usually ended up in the operating room."

He says, "On our trips, we take supplies that we know they need. We take the equipment and the expert who can fill that professional expertise...Finding the machine is the easy part; the hard part is finding somebody to go with the machine."

Because it is expensive to transport the equipment to Nigeria, they must carefully decide what to take. He says the hardest part of packing, shipping, and traveling with the supplies is to not waste time and money. They only take what they need, and leave about 95 percent of their equipment and supplies with the hospital.

Since medical supplies are very expensive, the Nigerians conserve many of the materials Americans consider disposable by sterilizing them with steam. As Dr. Ford explains, "We have a country of disposables, they have a country of reusables."

He illustrates: "On our first trip, I was doing a cesarean section with a resident, and he had a one-inch rubber tube for a suction machine. But the rubber tube had no tip. There was no plastic tip, no metal tip, just the end of a rubber hose. The second trip I took three dozen plastic disposable suction tips that I'm sure they will use for the next 10 years. Just that simple little item that we would have thrown away after one case will save hundreds of lives."

Suture material is valuable to the Nigerians because it is very expensive on the open market. Dr. Ford says, "That's one of the biggest things we try to encourage hospitals to save for us—suture. For [the Nigerians] to try to purchase that, it's almost impossible. They try to conserve right down to the very end of suture. At the end of the day, I would give what suture I had left in my pocket to the resident I was working with. That's very valuable."

Helping others help themselves

Education has been a driving force behind much of the World Health Mission's activities. The goal is to train others so they may help themselves—not in a teacher/pupil relationship, but to work together as a team. Dr. Ford says, "We try to take educational materials to Nigeria. All of us have presentations that we make to their staff. After the presentations, we leave the materials for their future residents."

Dr. Ford and the World Health Mission are responsible for helping to create the hospital's first university teaching library. "Two years ago, we sent over a library of 44 different journals—five years' worth. It took eight months to get there by boat, but now they have their first university teaching library. We now have journals from 1989 to send over. As the journals are microfilmed by the hospital here, they are available to send over."

When asked if the mission has considered assisting another hospital or country, he replies, "It would be hard for me to think there is any place that needs what we do any greater than this place. We've really established a fundamental role for ourselves [in Nigeria]. We are there at their invitation, not because we are from the U.S. and think they need help."

Dr. Ford poses with Nigerian physicians outside the university hospital in Jos.

Traveling for the mission

The World Health Mission is always willing to talk to people interested in joining the organization. Although a few residents have traveled for the mission in the past, Dr. Ford stresses that physicians should have some experience in practicing medicine. "You have to be able to get by if the oxygen runs out and you're operating on a patient; you have to be able to go along with what they do—and that is pump room air in until the operation is over." He adds, "You have to be interested in helping others and be willing to use physical diagnosis in a way that we were taught in medical school, but unfortunately because of our technological world, no one appreciates anymore."

There is a sense of adventure and excitement involved because a physician must use a "sixth sense" he says. "There is no liability, there are no third parties, there are no notes to write on charts. Basically, we can go and practice medicine in the pure sense. You try your best under the circumstances, and you realize that you can't help everyone. In general, each person has to have an overall purpose and a contribution that he knows he's going to make. That takes a little time to ascertain."

Dr. Ford's contribution to the Jos University Hospital in Nigeria is unparalleled. His efforts, and the efforts of all those who have participated in the mission, have relieved many heartaches and saved numerous lives. ⬡

For more information on the World Health Mission, contact: Karen Ford, Chief Operating Officer, World Health Mission, 2721 Oak Hill Drive, Allison Park, PA 15101; Phone: (412) 487-6611, Fax: (412) 487-5304.

Loyalty or Liability?

Lorraine Gregor, CPC

While many of your employees are likely to be an asset to your practice, some "loyal" employees aren't always what they seem. This articles offers guidelines for physicians to guard against "loyalty" becoming a liability that hurts you, your staff, and your practice.

It's human nature to trust people who have been employed by us for a number of years, but does longevity necessarily equate to loyalty? Not always. What exactly does *loyal* mean? Loyalty is not just showing up for work every day or working long hours; loyalty is not just the comfortable feeling of having had someone around for a long time. In fact, in many cases these employees are really more of a liability if they're not qualified or have not grown knowledge-wise with the practice. Loyalty is doing the job an employee was *hired* and *expected* to do.

Take, for instance, the multi-physician, multi-office specialty group that had promoted their manager up through the ranks because she started the practice 25 years ago with the senior partner, or the six-physician primary care practice that had a manager who also "fell into the position" because of her length of employment. In both cases, when the entire practice was evaluated, most of the problems pointed directly to the manager—not because these managers didn't try or care or put in long hours, but because they had never been trained to handle management tasks.

In both cases, training these managers proved unproductive because they had already destroyed their credibility with the physician(s) and other staff. In some areas they were just unable to reach a higher level of understanding. They were excellent in clinical areas, but not so when it came to business. Just because someone has been with your practice for a long time or wants to be a manager doesn't mean that person should be your manager.

In fact, you may find that you know more about the business side of medicine than the person you chose to guide you through the daily maze of changing regulations, coding games, and long-term planning. This can harm your practice in ways that may not be repairable or could take years to get back on track.

Avoid the "loyalty" pitfall

Before hiring from outside or promoting from within for any position, have a clear understanding of the duties of the position. Develop a comprehensive job description that includes the scope of the position, primary and secondary duties, requirements pertaining to education and experience, or expected skill level and authority bounds. Have staff complete a task assignment sheet listing their job title; who they believe they report to; the tasks they *actually* do each day, week, and month; and the approximate time involved in completing each task. Once this is accomplished, develop a job description that meets the requirements of each position in that practice.

Remember, just because someone hands you a job description from *another* office doesn't necessarily mean you'll be able to use it in *your* office. Develop your own. Only after you have a detailed list of what you really expect from a position can you begin your search for the *right person.*

If a current employee wants the position but doesn't have the right background or overall ability to fill *all* of the outlined, expected tasks, *do not* give them the position. Decide first if you're willing to invest the time and money in having them trained. If not, you may only be hurting your employees and your practice. Possibly having to face letting someone go that was an excellent secretary or assistant, but who makes an ineffective manager or billing supervisor, can be difficult, but putting the wrong person in a position can cost a practice thousands of dollars.

Familiar stories

One specialty practice had a problem with employees who consistently manipulated the physicians. These physicians were

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simply too nice, trusted the employees, and never reprimanded or terminated anyone. A bookkeeper in this practice refused to take a vacation and had total control of payroll, accounts payable, accounts receivable, and banking. It was discovered that this employee was stealing from the practice, not only taking cash from patient payments, but also paying some personal expenses through the practice's accounts payable system which she totally controlled. This employee had been with the practice about 14 years and was thought of as "loyal."

In another practice, an employee in charge of billing was generating claims and statements, but simply throwing them away—once again, stealing from the physicians. When confronted, this employee of almost 10 years denied she did this, even though evidence clearly pointed to this fact. She cried a lot, told the physicians she "cared about them and would do anything for the practice," and that our consultants were lying.

Against our recommendations, in neither practice were these employees terminated, because the physicians felt they were "loyal"—meaning they had been with the practices for many years. They were simply "demoted," *without* salary cuts. Both did eventually resign, but not without additional problems and added expense to the practice.

Both practices now have trackable audit controls and separation of duties with reporting mechanisms. No employee has total control of any function. The physicians also learned to read monthly reports, check activity quickly in their computers, outline expectations with their employees and accountants, and to not *blindly* trust employees, even "loyal," long-term employees.

An internal medicine practice noticed that expenses seemed to go up a great deal from one year to another, while patient loads had remained the same. In fact, with one physician temporarily off, schedules had been cut. Financial reports also revealed a changing pattern in two expense categories: In one year expenses for lab and x-ray supplies occurred every other month as they did for the first two and the last two months of the following year. However, from March through October of the second year, there were not only expenses every month, but the expensed amounts every two months were *exactly* the same. Supplies were ordered in quantities every two months, and this policy had not changed for years. Why were there expenses every month for eight months, and why were the figures exact to the penny?

Upon checking the microfilmed copies of checks, we found that the bookkeeper had written "extra" checks out to herself and her boyfriend. These physicians never reviewed the invoices. They signed checks as they were running out to the hospital. They trusted their "loyal" bookkeeper. This employee was fired. Thankfully, she was bonded, and the $80,000 found missing was covered. The physicians never pressed charges.

Amazingly, over the next 10 years, this same employee embezzled from at least nine other practices that we know about—and nobody ever pressed charges! It may be a hassle to prosecute, but what this employee did was break the law over and over again. Don't let someone do this to another of your colleagues. Remember, you might be next! Make sure all of your employees are bonded, have good audit controls, and monitor your practice monthly, and certainly quarterly, against previous years' activity.

If an employee is dishonest, terminate them immediately. Keeping them only condones their behavior and may set you up to the possibility of another employee doing the same. It's in your best interest to provide your employees with the controls that will keep them accountable. In most cases your employees will welcome guidelines and controls. It will also assure that money will be where it belongs—in your bank account. →

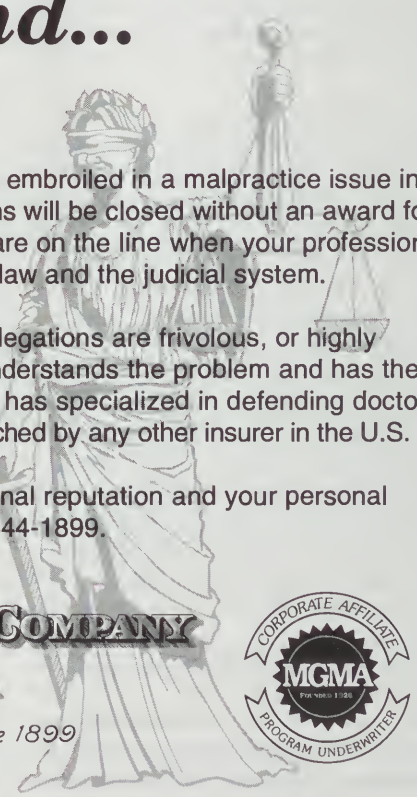
Guidelines to follow

Guard yourself against these unfortunate realities by following these easy guidelines:

- Hire qualified employees and give them a clear understanding of your expectations. Do not give an unqualified person control of your future. Pay your employees well.
- Make certain your practice has trackable audit controls set up and then followed. Have an independent audit done quarterly. This is a simple and inexpensive project. Have this done by an outside source who knows medical practice operations and billing, in addition to accounting.
- Be wary of employees who refuse to take vacations. Question managers who don't want anyone else to know how to post or do basic billing tasks, especially around payment issues.
- Learn how to look quickly at figures relating to gross charges, payments, overhead, and collection ratios. Monitor these figures weekly or at least monthly.
- Don't assume that just because an employee comes to work every day, they are doing their job. Set up goals and time frames for completing tasks. Monitor productivity. Make employees accountable and reward results.
- Avoid having "special" relationships with employees. Maintain a professional line with all employees.
- If you do have an employee who has been dishonest, don't make excuses for them. Terminate them immediately.
- Make certain your staff is continually trained and aware of changes in health care regulations, especially billing issues. Invest in educating your staff through workshops and seminars—it will ultimately help your practice be more efficient and productive.
- Be alert to managers or supervisors who always have problems but never seem to have any solutions. They may be in over their heads and taking your practice down with them.
- Pay attention today to red flags—decreased revenues, unhappy employees and patients, a manager who can't give you statistics—in your practice that may be pointing to other hidden problems. Tomorrow may be too late!

Not everyone is hiding something! It's your responsibility to give employees the tools to continue on a productive, accountable path for your practice as "loyal" employees.

...a promise to defend...



HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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TRACKING AND DEVELOPING PATIENT REFERRALS

As physicians vie for patient and network affiliation in today's competitive health care environment, getting the good word out about your practice becomes critical. But promoting your practice in a managed care arena involves more than just advertising in the local yellow pages. With a premium on networking, practices today need to bolster their marketing efforts by developing strong referral sources.

Referrals essentially come from three sources: patients who recommend you, professionals who refer patients to you, and plans and payer groups that promote you as a participating provider. But before developing strategies to attract new patients from these sources, you need to know where your existing referrals are and are not coming from. We suggest a referral tracking system.

A slight modification to your current registration routine will ensure that you are getting complete and accurate information for your referral tracking system. By including referral questions on your new-patient registration form, you will solicit information directly from your patients to input into your office computer system.

Each month, the data should be summarized in a report showing monthly and year-to-date totals by category. This report will clearly identify referral trends and let you know where your patients are coming from. Also, you will have a better idea of where you get the most benefit from promotional activities.

Sometimes patients are referred by multiple sources, or the source of the referral may be ambiguous. For example, a patient may have seen your yellow pages ad *and* had a neighbor's recommendation. Or, a previous patient or family patient referral may be disguised as a physician referral. A physician often directs a patient to see a specialist, but the patient may override the recommended physician and choose to be referred to you because of your good reputation or because you successfully treated a family member. Be sure the registration card begins with instructions for the patient to check off *all* items which apply.

By having better information on where your referrals are coming from, you will be able to identify your big supporters and express your appreciation. At the same time, you should be alert to the absence of certain referral sources and what you might do to cultivate new referrals.

If your referral system highlights a negative trend with a referring doctor, do not be afraid to contact the doctor and ask if there is a problem. If you are not getting patient referrals, perhaps you need to take a long, hard look at how your practice operates. Is your staff attentive and respectful toward patients? Are patients seen within a reasonable time frame? Do patients feel that you have taken the time to listen to their concerns? These perceptions all impact on whether patients will refer their family and friends to you.

Your tracking system should also pay careful attention to non-traditional referral sources, which, if cultivated properly, can be potentially good practice builders. These sources may include community or religious organizations, nurses or other ancillary providers, or pharmacists.

Physician prospecting

The best time to establish a relationship with a doctor is when he or she is just starting out in practice with no established referral pattern. Young physicians just out of training, or older ones just moving into the area, are often quite eager to get to know potential consultants to whom they can refer patients.

Personal contact with other doctors in the area, beginning with a letter and follow-up telephone call inviting them to lunch, should be a top priority for your physician referral development efforts. A "soft sell," get acquainted, see-if-we-can-be-of-service approach is usually effective.

Plan referrals

As more and more employers turn to HMOs and PPOs for health coverage, continue to ensure that your practice is participating with all plans that offer reasonable fees and terms. Beyond signing up with these plans, there are also strategies for capturing a larger share of these patients.

Primary care physicians play a key role in referrals. Specialists should identify the top 10 to 25 primary care practices within each managed care plan and send a personalized letter to each. This communication should inform the practice that you are now a participating provider and available to meet with them personally to determine how you could best serve their patients.

Plan enrollees

The enrollees of managed care plans still are able to exercise some degree of choice of doctor. As employers change plans, enrollees are forced to switch doctors more often than in the past, and for reasons that have nothing to do with quality of care. Your practice can initiate a number of marketing activities to increase the likelihood of plan enrollees choosing you for their care.

For example, many large plans produce subscriber newsletters. Contact the editors of these newsletters or the plan medical director and offer to have your practice author a special feature in each issue on your field of expertise. Also, find out which large employers are signed up with the plans in which you are participating. Many of these employers publish newsletters as well, and would be happy to receive a special guest column from a local physician participating in their plan.

Once you identify the major employers using the various health plans, you can also develop a presentation to be given over a lunch hour to employees on a relevant health concern. These types of initiatives give your practice visibility among a very targeted audience—working-aged men and women with insurance coverage. Moreover, by couching the entire thrust of your message in terms of health promotion, you dovetail with the philosophy of HMOs and the economic interest of employers—happy, healthy workers.

Referrals are essentially the life blood of your practice, and because they are so important, you need to have good information about them. A referral tracking system is an excellent way to observe trends, take corrective action if necessary, and continue doing more of the same if the trends are positive.

The author, Geoffrey T. Anders, JD, CPA, CBBC, is an attorney/consultant with The Health Care Group, Plymouth Meeting.

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Fourth Scope, One Year Later

Maria T. Montesano
Assistant Managing Editor

One year after implementation of the Fourth PRO Scope of Work, the president of the Keystone Peer Review Organization talked with PENNSYLVANIA MEDICINE about the changes and challenges of the new PRO process, and the organization's future.

Just prior to implementation of the Fourth PRO Scope of Work on April 1, 1993, Donald E. Harrop, MD, president of the Keystone Peer Review Organization (KePRO) anticipated "the most dramatic change to the PRO program since its inception in 1984." One year later, he says, "KePRO is adjusting very well, and the physicians are certainly much happier."

The new focus

The Fourth Scope—designed by the Health Care Financing Administration (HCFA)—brought two major changes to the peer review process in Pennsylvania: 1) reduction of individual case review, to review of patterns of care; and 2) shift from a punitive to an educational approach.

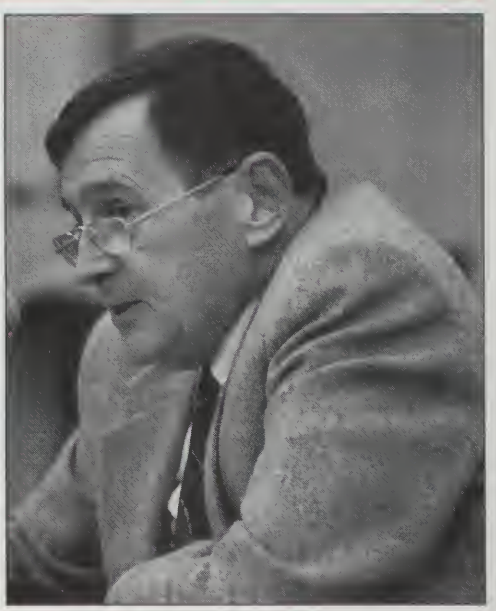
Dr. Harrop explains: "There has been a great decrease in the volume of individual case review, and rather, we're looking at the overall picture—pattern analysis—and offering educational information to physicians and hospitals."

Under this program, patterns of care are analyzed using HCFA's paid Medicare claims database—information that Dr. Harrop says "had been put to very little use" prior to the new approach. He says differences in treatment are identified, and "where it is obvious that one method is proved to be more successful than others, physicians will be informed through educational programs presented by the PRO at hospitals throughout the state."

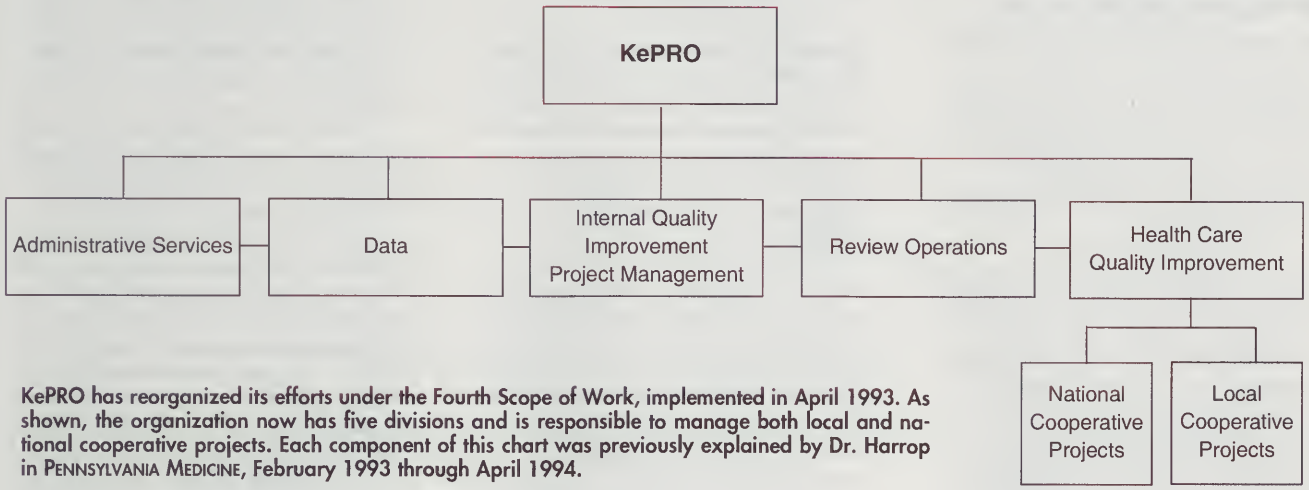
The biggest challenge of implementing the Fourth Scope, according to Dr. Harrop, has been changing mind-sets from the old focus to the new. "Initially, when

"The days of arguing about data collection and quality review are over. Data will be collected, and quality review must be done. We have to use the lessons we have learned in the past to guide us and help us move into the future."

— Donald E. Harrop, MD
KePRO President



KePRO's Reorganization



KePRO has reorganized its efforts under the Fourth Scope of Work, implemented in April 1993. As shown, the organization now has five divisions and is responsible to manage both local and national cooperative projects. Each component of this chart was previously explained by Dr. Harrop in PENNSYLVANIA MEDICINE, February 1993 through April 1994.

we go to hospitals to look at deviations in patterns of care, there is still some resentment, because they think our motives are punitive. But once they realize that what we're doing is comparing data for educational purposes, then there's been 110 percent cooperation."

He adds that changing mind-sets "has been a challenge for everyone—not only for physicians and hospital administrators, but for our employees as well."

Reorganization

KePRO has had to reorganize its operation under the Fourth Scope, including closing offices in Monroeville, Blue Bell, and Bloomsburg, and employing technical analysts. The organization now has five major divisions (see chart, above) and employs 183 workers: 153 in its Harrisburg headquarters, housed at the State Society's office building, and 30 in Tampa, Florida, where KePRO reviews Medicaid claims.

To carry out the primary purposes of the new scope—to improve the quality of care delivered to Medicare patients and to provide educational feedback to the deliverers of care—KePRO has hired a principal clinical coordinator, Lewis T. Patterson, MD, of Harrisburg. Dr. Patterson is responsible for deciding what patterns KePRO will study, for making sure the studies are properly done, and for communicating the findings to hospitals and medical staffs.

To oversee the small amount of individual case review still performed, KePRO employs a medical director, Alfred W. Meneely, MD, also of Harrisburg.

KePRO's future

Aside from HCFA's changes to the PRO program, KePRO must consider its role under whatever health system reform may come down the pike. Dr. Harrop says, "We're in a unique situation in Pennsylvania in that the Health Care Cost Containment Council is really one of the principle data collectors in the state. We shouldn't try to reinvent that wheel...to duplicate the council's effort."

Instead, he believes KePRO should continue to interpret and analyze the data, and communicate its findings to all interested parties—not only hospitals and physicians, but also to the purchasers and consumers of health care. "That role must be filled in any future system," he says, "and with our track record and capabilities, KePRO is the obvious one to fill it because that is something we know how to do...We are an independent provider of true quality review."

He adds, "The days of arguing about data collection and quality review are over. Data will be collected, and quality review must be done. We have to use the lessons we have learned in the past to guide us and help us move into the future...to build on the past and improve on it all the time."

Dr. Harrop contends that if KePRO continues what it's doing—looking at the needs of patients, physicians, hospitals, and purchasers of health care—and is able to fulfill those needs and continually improve health care, "then our future is quite bright." He adds, "KePRO's been around for almost a decade now, and I look for us to be around long after I'm gone."

SIX HEALTHNET SITES UP AND RUNNING IN PA

Telemedicine systems are now in place in six sites across the commonwealth as part of the PA HealthNet project to enhance the quality of health care in rural Pennsylvania by providing a telecommunications link to urban medical centers.

At the press conference announcing the initiative last year, Governor Robert P. Casey explained the project: "Using automated technology and communications, HealthNet will conduct remote exams, evaluations, and consultations; exchange patient information; access continuing medical education; and promote communication between rural practitioners and their urban counterparts."

Sites include: the Northeast Veterans Center (NEVC), Scranton; Wayne Memorial Hospital, Wayne; Temple University, Philadelphia; Penn State's Milton S. Hershey Medical Center, Hershey; University of Pittsburgh; and Cameron County Health Care Center, Emporium.

The first telemedicine consultations were conducted in January between Wayne Memorial Hospital and physicians in Scranton. The consultations addressed cardiology, neurology, and oncology issues. Other neurology consultations were performed between the hospital and the Hershey Medical Center in February and March.

To facilitate communication among the PA HealthNet sites, the coordinating task force is developing a physician referral directory. It will allow physicians at remote sites to identify physicians by specialty/subspecialty area who are interested in conducting telemedicine consultations.

At press time, installation of three additional systems was in progress for Glendale Area Medical Center, Coalport; Bradford Regional Medical Center, Bradford; and Charles Cole Memorial Hospital, Coudersport.

FTC GRANTS POWER TO MEDICAL SOCIETIES

The Federal Trade Commission (FTC) in February announced that medical societies now have the authority to require physicians accused of wrongdoing to participate in disciplinary proceedings, expel members from the society, disclose the unethical actions of disciplined physicians to the public, and report them to hospitals and state licensing boards. This action comes after a complaint to the FTC filed by the AMA and the Chicago Medical Society.

The FTC decision also allows medical societies to advise patients and insurers regarding a physician's fee and help them decide whether to pay a disputed bill. In its ruling, the FTC stated that any action taken by a medical society against a physician must be based on "fraudulent or unprofessional behavior" and not solely because one doctor charges a patient more than another. Under prior law, medical societies were not permitted to bring "price-related proceedings" against physicians because the FTC believed such action would result in price fixing.

AMA General Counsel Kirk B. Johnson, JD, says, "We intend to actively advise those medical societies that are conducting fee review of their expanded authority. We will advise those medical societies that have discontinued such committees to reinstate fee review committees."

PA FAILING TO ATTRACT FAMILY PHYSICIANS

Pennsylvania's family practitioners are not pleased with the state's results in the annual, national match of resident physicians with family practice residency programs which took place in March. Only 72 percent of Pennsylvania openings this year were filled, compared to 83 percent nationwide.

Thomas Weida, MD, president of the Pennsylvania Academy of Family Physicians and a member of the State Society, says the results are "another big wake-up call for Pennsylvania to get competitive." He explains: "Physicians often locate and practice in the region where they had their residency. So our ability to attract residents and keep residency graduates is critical to our primary care supply. But not only are we faltering in getting students in the residency match, last June almost half the graduates of these Pennsylvania family practice residencies left the state to practice somewhere else."

He adds that these trends are "unacceptable" in a state:

- that has declared a primary care shortage in 49 of 67 counties;
- where 12 million Pennsylvanians need and expect access to primary care services, and where there is a high per capita demand from older citizens and other groups;
- that has a large proportion of family physicians nearing retirement age;
- that boasts the nation's finest medical schools;
- that has a large concentration of quality residency programs; and
- that could be a lot more competitive in retaining and attracting primary care physicians.

MA Program Accepting HCFA 1500 Form

In response to recent legislation mandating the use of common billing forms, the Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (OMAP), is accepting the HCFA 1500 form effective April 1. The form can be used by all MA-enrolled providers, with the exception of short procedure units, hospitals, long-term care facilities, and dentists.

OMAP says:

- It will continue to accept and process the current MA invoice, "Physician's Invoice or Medical Service/Suppliers Invoice" (MA 319/319C), for those providers who prefer to continue using it.
- Pharmacists should continue to submit their claims on-line; however, they may use the HCFA 1500 to bill for medical supplies.
- Short procedure units should continue to use the MA 319 until notified otherwise.
- Outpatient hospital providers who bill for their salaried physicians may use either the HCFA 1500 or the MA 319.

Instructions for completing the HCFA 1500 are expected shortly in the *Medical Assistance Bulletin*. For more information, call the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

Eighteen of the commonwealth's 29 family practice residency programs did not fill their openings. "A major identified weakness is our practice climate," says Dr. Weida. "There's too much hassle and red tape...This is the area where state efforts must focus."

"No matter what your view of the current health system or ideas for change, there is consensus on the need for more primary care and family physicians in specific. And, there is increasing competition for these doctors between networks, like HMOs and PPOs, as well as among the states," he concludes.

"Pennsylvania has taken some positive steps, such as enacting loan forgiveness and creating a primary care task force in the Welfare Department, but now it is clearly time to get very serious about meeting this challenge."

COUNTY NEWS

PHYSICIANS PARTICIPATE IN ADOPT-A-SCHOOL PROGRAM

More than 110 physicians have volunteered to participate in the Physician Adopt-a-School Program, a cooperative effort of the Philadelphia County Medical Society, the School District of Philadelphia, Physicians for Society Responsibility, the Regional Council of Child Psychiatry, and the Philadelphia Pediatric Society.

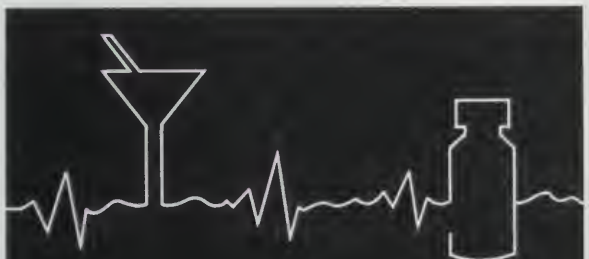
Paul J. Fink, MD, Philadelphia, piloted this program in June 1992 at the Peirce Middle School, which he describes as having "a population of around 650 students, all African-American, and an extremely dedicated faculty...The school is situated in a very poor neighborhood in which 91 percent of the children receive some form of aid (AFDC) and most of whom have experience with inner-city violence." He says the principal is "an extraordinary woman who combines intelligent leadership with an exquisite sensitivity and tireless dedication."

Among Dr. Fink's efforts, he spoke to the parents and faculty right after the new school year opened, gave a presentation at a faculty meeting, met with the Student Assistance Program team, worked with "some of the more difficult kids," and participated in the school's career day, where, he says, he learned more about the children than they learned about the medical profession.

His chief duty, however, was the "time-out" room. "The children characterized the time-out room as a jail. [It] was very uninviting—cold, silent, and purposeless," he says. "Most people share a common belief that children need to be 'tamed,' [but] in reality, children require great amounts of love, attention, and guidance during at least the first five to 10 years of their lives in order to learn how to love and be empathic and caring of others."

The principal and Dr. Fink, believing the children at the Peirce School already had lives filled with punishment, decided to redesign the time-out room "to help rather than hurt the children." In-service sessions were conducted to change faculty attitudes about the purpose of time-out, and the room was made "warmer, cheerier, [and] more attractive." Instead of using silence and fear as punishment, the faculty instituted counseling, art, discussion, and trust.

Look For Vital Signs



- Personality and/or behavior changes
- Unreliability and/or neglecting commitments
- Arrests for DUI
- Withdrawal from family and friends

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Maurice Romy, M.D.
Medical Director

The program officially started at the beginning of the 1993-94 school year. Dr. Fink concludes: "I have only been to the school once this year to follow-up, and [I] discovered that the greatest concern of the faculty was that 'the children *want* to go to the time-out room.' " He plans to continue his work with the school which he says is a "multi-year commitment."

As for the other 110 physicians participating in the program, each has received his or her school assignment for the fall and has contacted the school principal. For further information about the Physician Adopt-a-School Program, call the Philadelphia County Medical Society at (215) 563-5343.

Excerpted with permission from Philadelphia Medicine *1994; 90:152-53.*

HEALTHY LIFESTYLES FOCUS OF JUNE CONFERENCE

Each year, state health agencies and organizations—including the State Society—join together to promote comprehensive health education and wellness through the Keystone Health Promotion Conference. This year's event will be held June 20-24 at Susquehanna University, Selinsgrove.

Speakers will include JoAnne Owens-Nauslar, who has spent 20 years promoting the benefits of a quality lifestyle; Louis M. Slautterback, an elementary physical education teacher from Franklin, Pennsylvania; and Margarita M. Suarez, a nurse practitioner, counselor, and consultant from Issaquah, Washington, who practices in psychosocial nursing. Their presentations will focus on: self-esteem, wellness, conflict resolution, stress management, and self-image.

Also, the conference will offer:

- five days of healthy eating, learning, and playing;
- health screenings;
- interaction with colleagues from around the state who are interested in good health for Pennsylvanians; and
- competitive scholarships for teams attending the conference for the first time.

The conference is open to health care professionals, health educators, physical educators, wellness committees, principals, and superintendents. For more information, call (717) 787-9862.

DR. MURCEK SPEAKS AT REGIONAL SEPP MEETING

Dr. Murcek

State Society President Martin A. Murcek, MD, and Francis Davis, MD, publisher of "Private Practice," offered welcoming remarks at the March meeting of the Medical Action Committee for Education (MACE) of the Society for the Education of Patients and Physicians (SEPP), held in Greentree.

Edward Annis, MD, past president of the AMA who championed medicine's cause for almost 50 years, led "an impressive list of 16 outstanding national-level speakers," according to SEPP President Robert R. Urban, MD.

Also, a Canadian physician, who has practiced under both free enterprise and the single payer system, discussed the realities of the Canadian plan; and two physicians relayed personal stories of "taking on the federal government in defense of the profession and private practice." Other speakers included representatives from the fields of economics, business, insurance, federal government, and the pharmaceutical industry.

The meeting culminated with a presentation by Dr. Charles Van Eaton, a nationally known economist who heads the Economics Department of Hillsdale College in Michigan.

AMA-HMSS TO DISCUSS POLICY, POLITICS, REFORM

The AMA's Hospital Medical Staff Section (AMA-HMSS) will hold its 23rd assembly meeting June 9-13, 1994, at the Chicago Marriott Hotel. Aside from the usual policy-related activities, HMSS representatives will have an opportunity to talk with AMA trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

Friday's educational program will focus on:

- the impact of proposed legislation on the future practice of medicine,
- the kinds of managed care entities most likely to thrive,
- the ways to cope with health care delivery changes at the local level,
- the support needed to pass legislation on physician involvement in health system reform,
- the steps for developing a physician-directed health delivery network or plan, and
- the best methods for managing patient care and physician compensation in physician health plans.

For more information, call the AMA at (312) 464-4754 or (312) 464-4761.

PRACTICE PARAMETERS TO ADDRESS REHAB TOPICS

The Pennsylvania Academy of Physical Medicine and Rehabilitation is developing practice parameters to determine basic clinical services for patients with diagnoses which require rehabilitation services. Dennis Bonner, MD, Langhorne, and James Bonner, MD, Reading, have been appointed co-chairs of the development committee.

Hearings were held across the commonwealth in March to receive input on the development of parameter topics under consideration, including: closed-head injury, spinal cord injury, cervical sprain, myofascial pain, carpal tunnel syndrome, stroke, and hip fracture.

Physicians who wish to comment on these topics, or who would like to be involved in the development process, should call Dr. Dennis Bonner at (215) 752-0200 or Dr. James Bonner at (610) 532-2633.

THORACIC MEETING SET FOR SEPTEMBER

The joint scientific session of the Pennsylvania and New Jersey Thoracic Societies, as well as the Annual Membership Meeting of the Pennsylvania Thoracic Society, will be held at the Hotel Atop the Bellevue, Philadelphia, on September 9-10, 1994.

Sessions include topics on symptom management, practice issues, pulmonary manpower, COPD, and smoking cessation. Category I CME credits are offered. For information, call Charles J. White, executive director, at (717) 540-8506.

ST. CHRISTOPHER'S RECEIVES $3.1 MILLION GRANT

St. Christopher's Hospital for Children, Philadelphia, has been awarded a $3.1 million grant for research on improving health care for children with sickle cell anemia. The five-year grant is part of the Minority Health Initiative, which was initiated by the National Institutes of Health.

The grant will fund basic and clinical research in lung disease and pain management in children. Areas of research will include: lung disease complications, pathophysiology of respiration, sleep apnea in children with sickle cell anemia and how that may precipitate the occurrence of pain crises, and drug metabolism of some analgesics.

COSTS OF HEART DISEASE HIGH ON HOSPITAL BILL

Diseases of the circulatory system account for more than a fifth of the nation's hospital bill—estimated to total $145 billion—according to a recent study of 1987 hospital charges conducted by the Agency for Health Care Policy and Research (AHCPR).

The study found that the single most expensive health problem in hospitals was ischemic heart disease. Charges for that disease totaled nearly $9 billion, followed, respectively, by normal childbirth at $5.5 billion; cerebrovascular disease and pneumonia/influenza, each of which cost roughly $5 billion; complications of childbirth at $4.7 billion; acute myocardial infarction, $4.6 billion; congestive heart failure, $4 billion; fractures (other than of the hip), $4 billion; medical complications from use of a device or procedure for diagnosis or treatment, $3.1 billion; and gallbladder disease, $3 billion.

The study also analyzed charges by type of payer. Medicare received the highest bill—nearly $64 billion—followed by private insurance, whose hospital charges totaled roughly $50 billion, and Medicaid, which was billed just under $14 billion. Other payers accounted for the balance.

According to AHCPR, the study is the most detailed examination ever conducted on a national scale of hospital charges for specific diseases and conditions. For more information, write AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907; or call (800) 358-9295.

CORRECTION

In *Newsfronts* of the March 1994 issue of PENNSYLVANIA MEDICINE (page 44), the last name of the guest of honor at the annual scientific meeting in June of the Pennsylvania Academy of Otolaryngologists-Head and Neck Surgery was spelled incorrectly. His full name should have read: Fred J. Stucker, MD.

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Dr. McAfee

Robert McAfee, MD, AMA president elect, presented the Chairman's Lecture for Pennsylvania Blue Shield on March 17 at the Philadelphia County Medical Society.

Milton J. Freiwald, MD, emeritus staff member, Albert Einstein Medical Center and Women's Hospital, Philadelphia, was honored to mark the 50th year anniversary of his graduation from New York University College of Medicine, and presented with an award for his "unselfish devotion and distinguished service."

Jeffrey J. Dekret, MD, was appointed chairman, Department of Psychiatry, Fitzgerald Mercy Hospital, Darby, and Misericordia Hospital, Philadelphia.

Marc W. McKenna, MD, was appointed director of the Family Practice Residency Program and Family Practice Unit, Chestnut Hill Hospital, Philadelphia.

David J. Shulkin, MD, director, Office of Clinical Outcomes Assessment and Quality Management, and assistant professor of medicine, Hospital of the University of Pennsylvania, Philadelphia, was appointed the hospital's chief medical officer.

St. Francis Health System, Pittsburgh, has named **Elmer J. Holzinger, MD,** senior vice president of academic affairs and development.

Albert L. Pizzica, DO, director of pediatrics and neonatology, Episcopal Hospital, Philadelphia, was elected 1994-96 president, Philadelphia Perinatal Society.

James H. Herndon, MD, David Silver professor and chair, Department of Orthopedic Surgery, University of Pittsburgh School of Medicine, was elected treasurer of the Board of Directors, American Academy of Orthopedic Surgeons.

Harold J. Isard, MD, chair emeritus, Department of Radiology, Albert Einstein Medical Center, Philadelphia, and clinical professor of radiology, Temple University School of Medicine, has earned the Philadelphia Roentgen Ray Society's Distinguished Teacher Award.

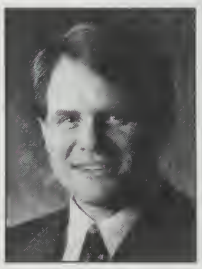
Stephen M. Soll, MD, Soll Eye Associates, Philadelphia, has co-produced with **Richard Lisman, MD,** and **Mark Weiner, MD,** both of New York, a video biography entitled, "The Life and Career of Bryon C. Smith, MD, An Innovator in Eye Plastic Surgery."

Walter Schwartz, DO, Brookhaven, was elected to the board of directors, American Heart Association of Delaware County.

The Philadelphia College of Osteopathic Medicine (POCM) opened a clinical learning lab for its Standardized Patient Program, to meet the increasing concerns of the public that many doctors need better listening and communication skills during physician/patient visits. Participating in the ribbon cutting are (left to right): Jeffrey S. Freeman, DO, clinical director of the lab; Kenneth J. Veit, DO, MBA, PCOM dean; Anthony M. Errichetti, PhD, program consultant and coordinator; Leonard H. Finkelstein, DO, PCOM president; and Matthew Haley, PCOM student council president.

In recognition of outstanding performance in research, education, and clinical medicine, the Temple University School of Medicine, Philadelphia, has named **Ward E. Bullock, MD,** Cincinnati, Ohio, alumnus of the year.

Chestnut Hill Hospital, Philadelphia, has named **Eugene Hughes Jr., MD,** chief of general surgery.



Dr. Lyons

Daniel Lyons, MD, was appointed vice president of medical affairs, Independence Blue Cross, Philadelphia. Dr. Lyons is responsible for health care management of traditional indemnity and personal choice subscribers.

Risa J. Lavizzo-Mourey, MD, was appointed to the newly created position of associate executive vice president for health policy, University of Pennsylvania Medical Center and Health System, Philadelphia, and as associate dean for Health Services Research at the medical school. Also, **Garret A. FitzGerald, MD,** was appointed chief-designate of the medical center's proposed Center for Experimental Therapeutics, Department of Medicine.

At the sixth annual awards ceremony celebrating the minority osteopathic physician, sponsored by the Student National Medical Association (SNMA) of Philadelphia College of Osteopathic Medicine, **A. Scott McNeal, DO,** Philadelphia, was presented the 1994 Meta Christy Award, in recognition of his exemplary practice of osteopathic medicine, service to the community, and inspiration to future DOs. Also, SNMA presented **Carl R. Pullen, DO,** Germantown, with a Mentor Award.

David Brent, MD, associate professor of psychiatry, and chief, Division of Child and Adolescent Psychiatry, University of Pittsburgh Medical Center's Western Psychiatric Institute and Clinic, was awarded the 1993 Beatrice Cummings Mayer Award from the American Academy of Child and Adolescent Psychiatry for the best articles on suicide or depression submitted to the academy's journal.

OBITUARIES

Philip Berg, MD, *Bellaire, TX*
Jefferson Medical College of Thomas Jefferson University, 1938; age 81, died January 2, 1994. Dr. Berg was a general practitioner.•

Morris A. Bowie, MD, *Newtown Square*
Harvard Medical School, 1929; age 90, died February 1, 1994. Dr. Bowie was a rheumatologist.•

Robert Cohen, MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1948; age 68, died January 21, 1994. Dr. Cohen was a pediatrician.•

Nathan N. Ginsburg, MD, *New Castle*
Hahnemann University School of Medicine, 1932; age 89, died January 9, 1994. Dr. Ginsburg was an obstetrician/gynecologist.•

Robert G. Goldstrohm, MD, *Indiana*
University of Pittsburgh School of Medicine, 1951; age 68, died February 20, 1994. Dr. Goldstrohm was an ophthalmologist.•

Philip E. Kistler, MD, *West Chester*
Temple University School of Medicine, 1955; age 63, died February 6, 1994. Dr. Kistler was a family practitioner.•

Morris Kleinbart, MD, *Philadelphia*
Jefferson Medical College of Thomas Jefferson University, 1925; age 92, died February 28, 1994.•

Guy L. Kratzer, MD, *Allentown*
Temple University School of Medicine, 1935; age 82, died March 18, 1994. Dr. Kratzer was a colon/rectal surgeon.•

John J. Madonna, MD, *Emmaus*
Temple University School of Medicine, 1947; age 70, died February 28, 1994. Dr. Madonna was a general surgeon.•

Grace L. Riethmiller, MD, *Sewickley*
University of Pittsburgh School of Medicine, 1940; age 82, died January 19, 1994. Dr. Riethmiller was an obstetrician/gynecologist.•

Joseph E. Shelby, MD, *Uniontown*
Temple University School of Medicine, 1938; age 83, died January 13, 1994. Dr. Shelby was a general practitoner.•

George A. Dunkelberger, MD, *Lancaster*
University of Pennsylvania School of Medicine, 1933; age 89, died February 13, 1994. Dr. Dunkelberger was a general practitioner.

Charles C. Guyer, MD, *Montrose*
Hahnemann University School of Medicine, 1947; age 77, died February 6, 1994.

Newton W. Hershner, MD, *Mechanicsburg*
University of Maryland School of Medicine, 1941; age 78, died February 7, 1994. Dr. Hershner was an obsterician/gynecologist.

Boyd N. Park, MD, *Butler*
Temple University School of Medicine, 1951; age 67, died January 25, 1994. Dr. Park was an anesthesiologist.

Paul T. Poux, MD, *Guys Mills*
University of Pennsylvania School of Medicine, 1949; age 67, died January 15, 1994. Dr. Poux was a general practitioner.

Nicholas S. Nicholas, DO, *Drexel Hill*
Kirksville College of Osteopathic Medicine, 1939; age 76, died January 26, 1994.

Rajeswari Suseelan, MD, *Clarks Summit*
Madras Medical University, India, 1973; age 46, died February 3, 1994. Dr. Suseelan was a family practitioner.

Charles Fineberg, MD, *Philadelphia*
Hahnemann Univesity School of Medicine, 1950; age 73, died February 14, 1994. Dr. Fineberg was a general surgeon.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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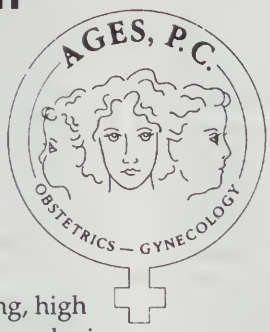

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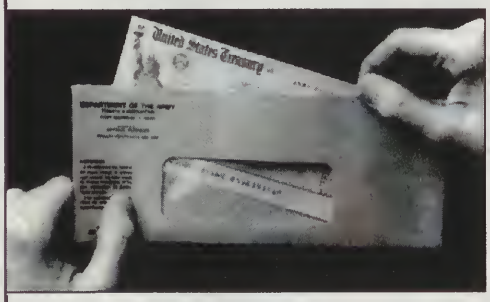

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When you examine clinical practice data by DRG in a setting supportive of nurse/physician/management collaboration, the program rapidly focuses on acknowledging that there must be a better way and then defining what that way is. For example, our institution examined hip replacements and asked our physicians to identify an ideal progression after sharing with them their actual utilization data and the national norms for length of stay and charges. That same week they returned to us, having met formally with all the orthopedists and medical consultants, with a care plan that conformed to the national standards and outlined day by day exactly what treatments and therapies would be required. In addition, the plan began six weeks prior to hospitalization and extended six weeks beyond hospitalization, outlining all of the preoperative evaluation steps and all of the postoperative community based continuity steps.

This plan was then provided to our nursing, allied health, and management staff who overlaid their own plans so that it would be comprehensive. We identified the hospital processes that needed to be improved to support the new plan and modified our medical records so that each day of inpatient hospitalization for hip replacement, the critical pathway for that day appeared in a window in the left hand side of the progress note. This provided the capacity for charting by exclusion for our nursing staff and a system for monitoring our own performance against the standard that we had set within this care pathway.

Added bonus: We were then able to take this clinical plan and share it with payers to demonstrate our cost-effective, value-enhanced approach, as well as to confirm that interprofessional collaboration was part of our institutional mission.

While physicians have been largely unenthusiastic about quality assurance activities in the past, it is not because we don't want better patient care. It's because those activities have not worked. In contrast, the creation of care paths provides a coordinate standard of care and a defined approach by diagnosis. This then forms the basis for measurement of performance and continuous modification to improve the consistency of the outcome, and the efficiency and accessibility for the patient and physician. When you can expect what will occur, you have more time to plan and more time to spend with the patient.

The concentration of doctors, nurses, and managers on building a better system around patient services is inherently a self-rewarding activity, and careful critique places us in a stronger leadership position and in good control of our own destiny. This data is complex with many ramifications. In the absence of our own aggressive self analysis and construction, the data is interpreted, manipulated, and refined by non-providers often unfamiliar with the daily care of patients.

Hospitals possess clinical practice data but are afraid to share it, fearing it will explode already tenuous medical staff relationships. Physicians must encourage hospitals to share this data and help design constructive forums for its analysis and use.

Dr. Magee is senior vice president at Pennsylvania Hospital, Philadelphia. This article is excerpted with permission from his **Geometry of Physician Relations** *series.*

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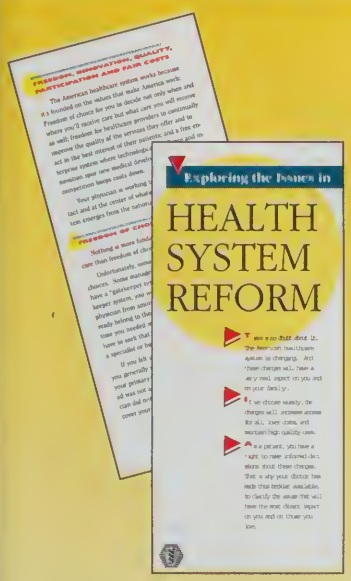

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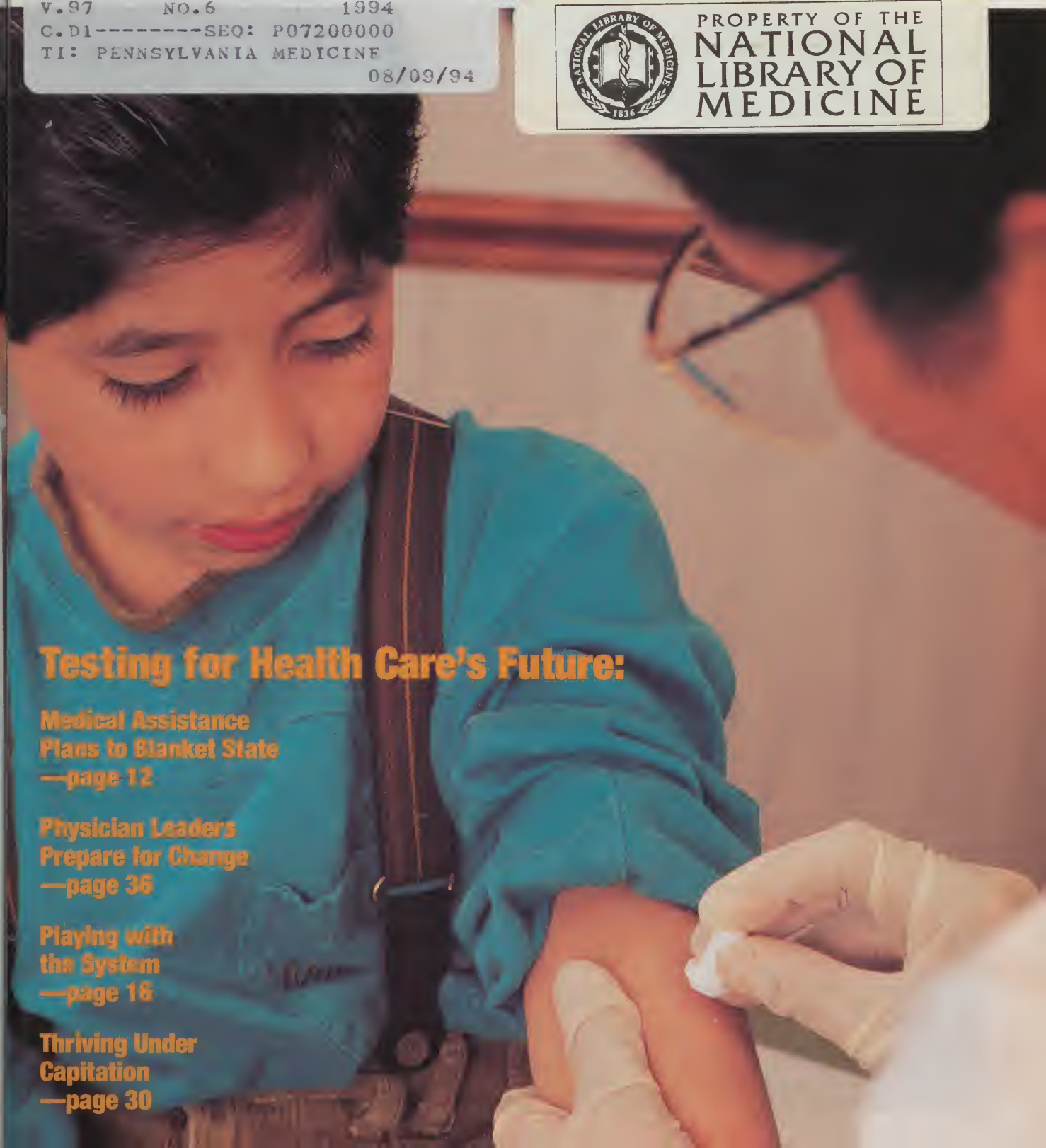

Testing for Health Care's Future:

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Physician Leaders Prepare for Change —page 36

Playing with the System —page 16

Thriving Under Capitation —page 30

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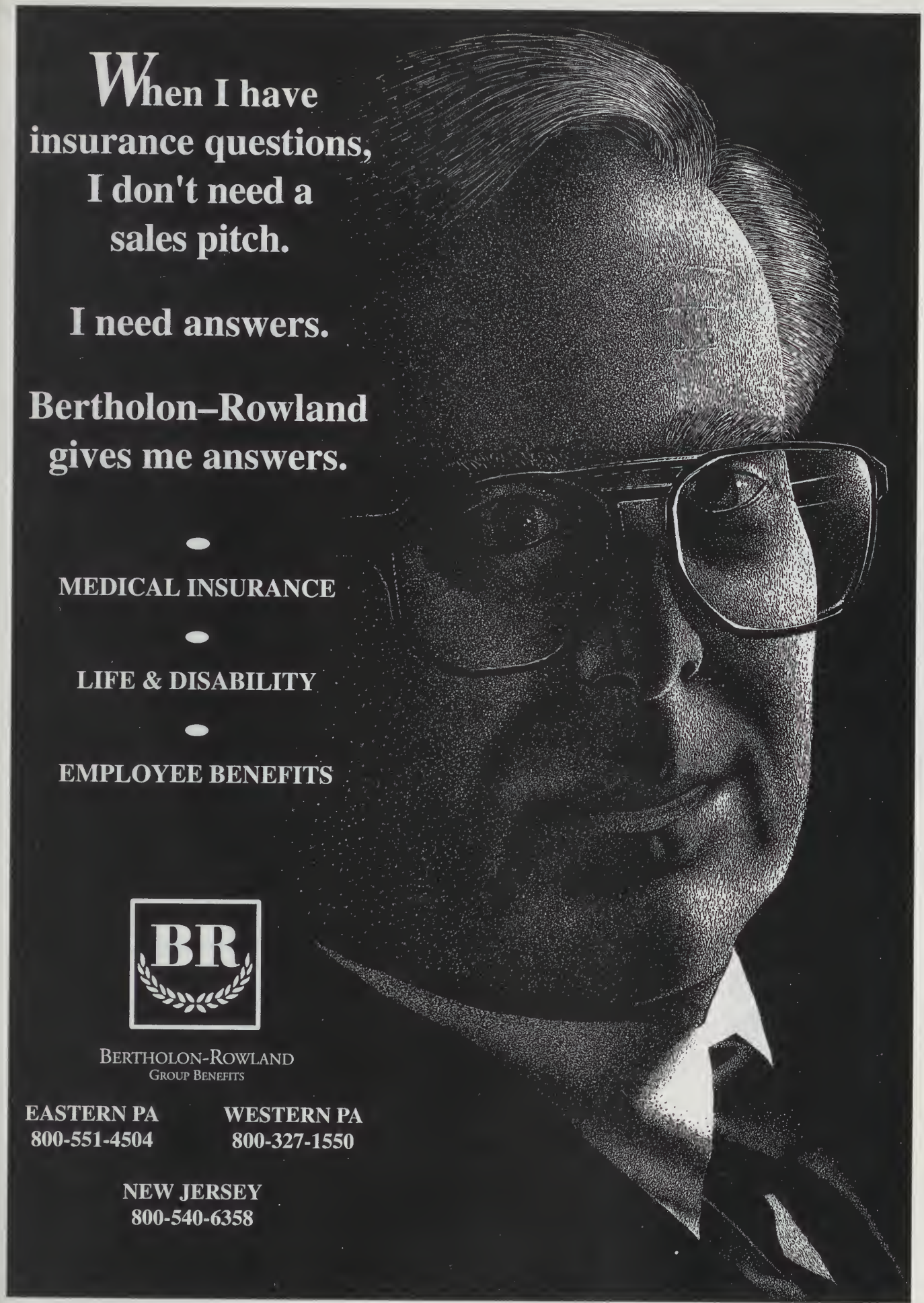

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Cover photo by Blair Seitz©, Harrisburg

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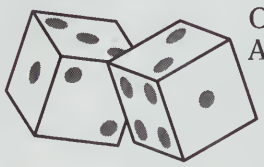

One Society member considers the ABCs of life, politics, and medicine.

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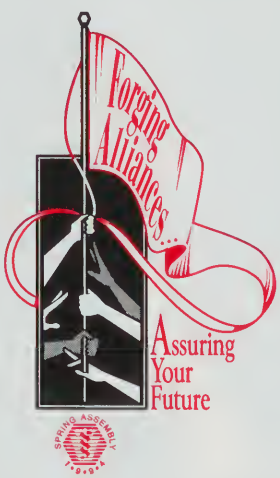

To prepare physicians for the changes to come and the roles they may be asked to play under health system reform, the Society focused its annual Spring Assembly on "Forging Alliances...Assuring Your Future." Coverage appears in Newsfronts.

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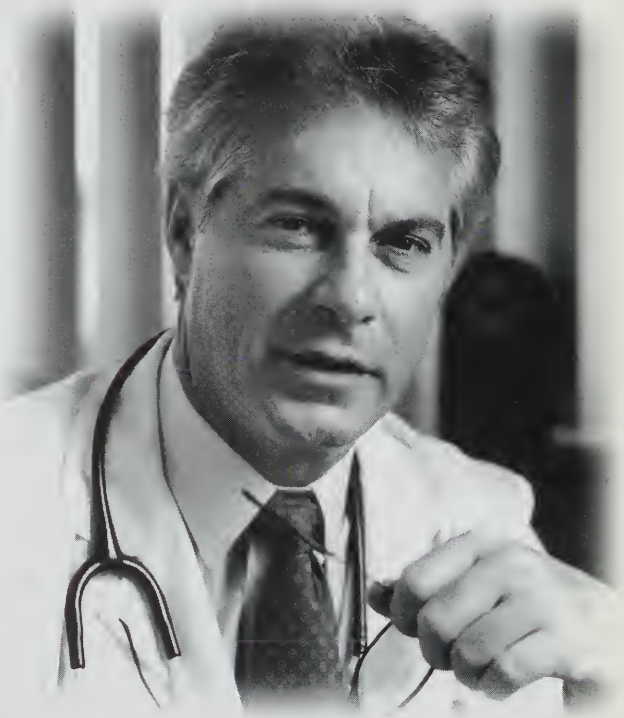
"Unfortunately,

he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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SENATE PASSES OPTOMETRY BILL; HOUSE COMMITTEE REVIEWING: The Senate on May 17 passed by a vote of 29-18 Senate Bill 1061, which proposes amendments to the Optometry Practice Act to expand optometry's scope of practice. The bill would allow optometrists to use therapeutic agents without input from a physician in the creation of clinical training standards. *Physicians are encouraged to contact their state representatives to oppose the bill,* which has been referred to the House Professional Licensure Committee. A vote is not expected until fall.

SOCIETY OPPOSING NEW HOUSE BILL: The State Society and the Pharmaceutical Manufacturers oppose newly introduced *House Bill 2733,* which would require physicians to document a potential adverse reaction if a brand name drug is desired in place of a generic drug for patients of the Department of Aging's Pharmaceutical Assistance Contract for the Elderly (PACE) program. Representative Kevin Blaum (D-Luzerne) introduced the bill to generate savings to allow more seniors to participate in the program; the Society contends that it creates another paperwork requirement for physicians. The bill was referred to the House Aging and Youth Committee, chaired by Representative Blaum, for consideration this month.

In related news, three other bills addressing medical issues have been introduced in the legislature: *House Bill 2845,* introduced by Representative Dante Santori (D-Berks) and referred to the House Health and Welfare Committee, would provide a tax credit to businesses that allow special employee paid leave for bone marrow donation; *Senate Bill 1724,* introduced by Senator Ed Holl (R-Montgomery) and referred to the Senate Banking and Insurance Committee, would require insurance coverage for cancer treatments; and *Senate Bill 1661,* introduced by Senator Stewart Greenleaf (R-Montgomery) and referred to the Senate Judiciary Committee, would provide power of attorney for health care.

AMA PUSHING PATIENT PROTECTION ACT: The American Medical Association (AMA) on May 23 introduced the Patient Protection Act—legislation to ensure that health care treatment decisions are made by patients and physicians, not insurance companies. The insurance industry responded immediately with a massive campaign against the act, and the AMA is seeking individual member support. An all-physician AMA mailing was scheduled for June 1, and the organization is preparing patient brochures explaining the act. For more information, see page 29.

PHYSICIANS NAMED TO PMSCO BOARD: Eight Pennsylvania physicians have been named to the Board of Directors of the Society's newly formed subsidiary, PennMed Member Services Company (PMSCO). They are: **Jeffrey H. Chaby, DO,** Lancaster; **Edward H. Dench Jr., MD,** State College; **John E. Devenney, MD,** Norristown; **Edward R. Jones, MD,** Philadelphia; **George R. Fisher III, MD,** Philadelphia; **Michael J. Prendergast, MD,** chair, York; **James R. Regan, MD,** vice chair, Bethlehem; **Marc J. Schneiderman, MD,** Coraopolis; and **Anne Woods, MD,** York. Also, **Roger F. Mecum,** Society executive vice president, will serve as secretary/treasurer. PMSCO will provide practical, physician-directed consulting and practice management services to physicians.

DR. GRECO ELECTED CHAIR, STATE BOARD OF MEDICINE: Victor F. Greco, MD, the Society's Twelfth District trustee, was elected chair of Pennsylvania's State Board of Medicine on May 24. Members of the board chose Dr. Greco of Drums to succeed Joshua Perper, MD, who resigned from the board to accept a position in Florida.

FOUNDATION FINANCING EXAMINATION OF HEALTH SYSTEM REFORM: The Robert Wood Johnson Foundation has bought a two-hour block of prime time on NBC television and has asked the network's news division to fill the slot with an "ambitious examination" of health system reform. The special program will be broadcast without commercials on June 21 from 9:00-11:00 p.m. The foundation paid $2.5 million for the air time, and will provide another $1 million to promote and advertise the special.

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Beware the Golden Calves of Las Vegas

John W. Mills, MD
Medical Editor

Time magazine on January 10, 1994, "covered" its publication with the Golden Sphinx of the Luxor Casino-Hotel and referred to Las Vegas as "the new All-American City." My initial impression of that cover conjured up a scene from "Moses," that colossal film by MGM, portraying the words of Exodus 32:1-6 in which the people "formed a molten calf and altar, [and] sat down to a feast which turned into an orgy of drinking and sex." That same week, the *Kiplinger Washington Letter* predicted that "gambling will be the fastest growing industry of the '90s."

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Legal betting totaling $330 billion each year is a big business! To put it in perspective, annual health care expenditures in this country total more than $650 billion, and President Clinton's plan would cost about $331 billion in new taxes. Our country cannot continue to squander these huge sums on instant self-gratification.

Consider for a moment some interesting *Time* statistics: Las Vegas has the second highest lung cancer rate in the country and the highest suicide rate; of the city's 22 million visitors, nearly half are under age 30; and violent crime and murder rates for Las Vegas are now only slightly higher than the national averages, probably because the rest of the country has come to resemble Las Vegas.

Remember that gambling "brings problems along with jobs and tax revenues—bankruptcies, divorces, organized crime, and child support delinquencies," to quote Mr. Kiplinger.

As I opined before on these pages, America's moral fiber has lessened considerably, and I believe we are in danger of self-destruction if we continue this downward spiral. Our search for sensual extended gratification is embodied by the golden glitter of Las Vegas. Our state lotteries have spurred the get-rich-quick mentality which permeates our society.

This last issue is responsible in no small way for our huge increase in malpractice suits, both from the patient's perspective and from the legal community which disguises its focus—huge monetary awards and thus fees—as weeding out the bad doctors and hospitals. Unfortunately, much of this activity is really maloccurrence; and because of the trend toward increasingly impersonal medical encounters, it's easy for the patient and attorney to see "big bucks" from known deep pockets—state law requiring heavy coverage.

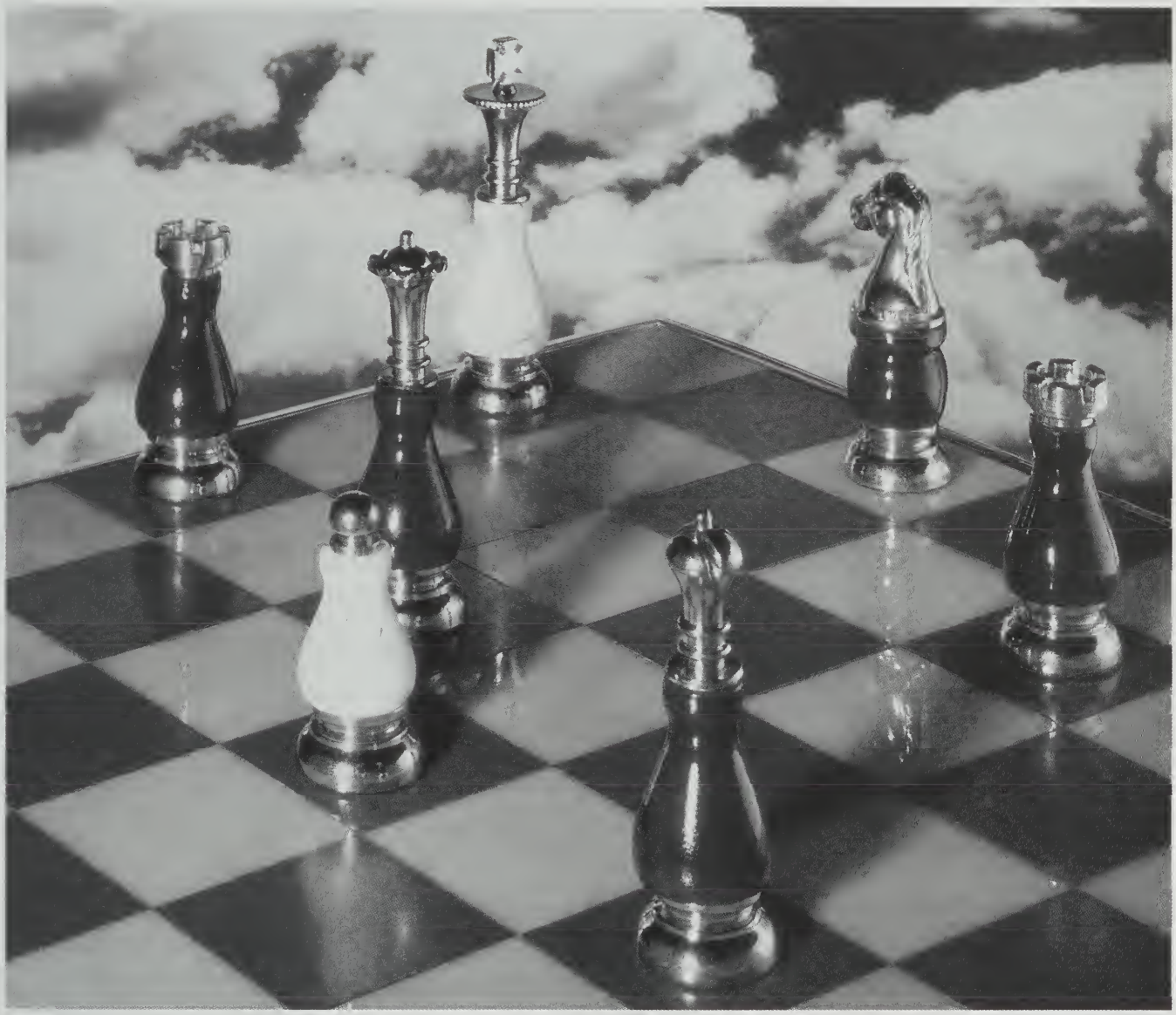
Our loosening of moral fiber has also translated itself into a justice system that is ineffective. The legal community bends over backwards to give "rights" of all types to everyone, and just when we need better control to deal with our violence and drug problems and our national dishonesty, we have a justice system that is politically motivated and tolerant beyond belief—searches for weapons in public housing riddled with crime violate the Fourth Amendment because they are "unreasonable," according to the ACLU.

Physicians have always had a very high ideal to follow—the Hippocratic Oath. But we, too, are guilty of the get-rich mania around us.

Remember, ladies and gentlemen, there is no free lunch. A country that tries to survive on gambling revenues will either be taken over by organized crime or eventually burn itself out into oblivion. Such revenues will eventually top out, and we will pay the piper in high tax increases or severely cut services.

The real meaning of all this for us and our profession is quite simple. We need to stick together and join in some common goals: tort reform *now*, encompassing a non-economic damage limit to $250,000 and caps on lawyers' fees; freedom to choose one's personal physician, just as our president has; a standard benefits package for all citizens; the right to purchase excess health insurance (not duplicate); and finally, to monitor ourselves to provide care that is cost effective and medically appropriate, and to work to bring our colleagues into compliance.

Our mission is awesome: to be competent individuals focused on helping our fellow man. We must be conscionable men and women as examples for our society to emulate. Let us be fully aware of what the golden calves of Las Vegas and what instant gratification really mean: perhaps, as *Time* put it, "one more symptom of the decline of Western civilization."



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Scattershot Approach Pleases Clintons

Martin A. Murcek, MD

Excerpted from Dr. Murcek's address on April 20 to attendees of the State Society's 1994 Spring Assembly.

An issue that has been bothering me for a while now is the scattershot approach of the various specialty societies that have, in one form or another, thrown in their lot with the Clintons on behalf of the health system reform plan. It is one thing for specialty societies to say that they are throwing support behind the Clinton plan because they want to have a place at the bargaining table. What they have in fact done is another thing—appearing on stage as enthusiastic Clinton plan supporters.

As Senator Dick Armey from Texas says, "From their places at the table, they will ultimately become the main course."

I sincerely doubt that the position espoused by the leadership of these groups reflects that of their rank-and-file members who are in active practice. In my many years of experience with specialty societies, I have too often seen situations where the leadership consists of physicians who have left the ranks of their active-practice colleagues. Clearly, this is a reflection of the fact that active practice entails considerable time commitment, compared to the lesser time demands experienced by physician-employees or retired physicians. This situation results in leadership ranks with few, if any, active-practice physicians participating.

Consider retired physicians in leadership roles; the increase in regulatory hassles and the paperwork explosion that has occurred in the last few years hasn't impacted them. Unless they are hearing from active practice physicians about these ever-mounting headaches, they are probably oblivious to the drag that red tape is placing on the typical actively practicing physician's practice. It's always easy to support more government paperwork when you don't fill any out anymore. It's easy to agree to fee caps and fee deductions when you don't collect fees any longer. Don't get the wrong idea; I'm not disparaging retired physicians for being retired; I look forward to being one myself someday.

Also, consider physician-employees. They are shielded from a good portion of the cost of doing business by the organization that employs them. Some physicians have opted to be employees for exactly that reason, and there's nothing wrong with that. It is true, however, that "out of sight is out of mind," and this lack of perspective translates into a willingness to "compromise" active practitioners right out of business by cozying up to the federal government's plan.

Dr. Gary Levin, medical director of Gould Medical Group of Modesto, California, is quoted as saying, "I expect to convert my physicians to a salary system within a few years." Gerry Benedict, Gould's former CEO, a nonphysician, points out, "Physicians resist being salaried because it's difficult to monitor and evaluate their performance, [and] the bureaucracy and controls to appraise each doctor are large and viewed as 'Big Brother.'"

If you have to do the paperwork, however, and you have to collect enough in fees to meet an office payroll, purchase supplies, pay licensing and regulatory fees, keep the phones and lights on, and wrestle with insurance companies, HMOs, PPOs, etc., you don't need any additional forms to fill out or constraints on charging reasonable fees.

Some physicians wonder whether their specialty society's leadership have talked to any of the rank-and-file active-practice members before announcing their unfortunate positions on the Clintons' plan. I hope this serves as a wake-up call to younger physicians—it's tougher than ever for a young physician to find time for involvement with their specialty society's leadership hierarchy, but it is their involvement that can turn the group around.

Physicians just beginning to practice need strong, unified, organized medicine leadership that will fight to preserve our quality of medical care and practice environment. We practice the best medicine in the world here in America; let's get organized medicine's leadership all on the same page, committed to keeping it that way. It's time for us to forge alliances putting physicians back in charge where they belong!

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LETTERS TO THE EDITOR

DELEGATES MUST REFLECT DESIRES OF MEMBERSHIP

I have read with interest Dr. John Mills' editorial, "Further Thoughts on Health Reform" [PENNSYLVANIA MEDICINE, March 1994, page 6]. I support his call for physicians nationwide to unite. Indeed, it is our only chance.

I object, however, to his contention that the Philadelphia County Medical Society is the villain who has brought about the division in Pennsylvania over a single statewide Medicare charge class. It is clear to me that the divisive action was the action taken at the House of Delegates meeting in October 1993.

The Philadelphia County Medical Society knew then, and subsequent facts have proven, that the overwhelming majority of Pennsylvania Medical Society members and nonmember physicians in Pennsylvania oppose conversion to a single locality. He states that the House action was a democratic process. What could have been more democratic than the Philadelphia County Medical Society seeking the opinion of thousands of physicians in Pennsylvania?

Rather than using this experience as an opportunity to bash Philadelphia, I suggest we use it to force the House of Delegates to reflect on its responsibility to its members. The vast majority of the medical societies in counties where physicians would have experienced a decrease in Medicare reimbursement under a single locality subsequently opposed the petition. I have personally received copies of 2,200 letters from physicians which were sent to the Health Care Financing Administration opposing the petition. I am sure I have not received copies of all letters which were sent.

When was the last time that many physicians felt so strongly about an issue that they took time to write on their own letterhead? Federal health system reform may very well impose a nationwide charge class, and we may have little to say about it, but we will not tolerate our own Society leaders imposing it upon us.

The House of Delegates clearly did not sense the pulse of physicians in Pennsylvania on this issue. Lacking this awareness, the delegates took a divisive action. The lesson to be learned is that when there is no need for radical immediate action, delegates should take time to insure that they are reflecting the desires of their membership.

William S. Frankl, MD
President
Philadelphia County
Medical Society

Response: Thank you for your letter. The editors appreciate your comments and your support. You need to understand, however, that Society leaders did not impose anything on anybody.

The House of Delegates is responsible only to their county constituencies. Indeed, the House should continually reflect on its responsibility to Pennsylvania Medical Society members, as well as nonmembers, since statewide actions affect all Pennsylvania physicians.

In this case, Society staff and leaders carried out the House decision—to request from the Health Care Financing Administration (HCFA) a single statewide charge class. That is our duty as noted in our bylaws. And HCFA determined, by the large number of "no" votes via letters which you garnered, to turn down the House's action.

Perhaps the delegates did not sense the pulse of Pennsylvania physicians—but they did feel strongly enough to vote it up, and sometimes that takes courage!

Interestingly, Ohio and Oklahoma—states which also have big cities and small rural counties—both recently requested the same action, and it was granted by HCFA. Perhaps we and "the city of brotherly love" could learn from them how to be less divisive.

John W. Mills, MD
Medical Editor

TALE OF A TOENAIL

Editor's Note: Edward A. Lottick, MD, editor of the Bulletin of the Luzerne County Medical Society, *recently called this letter to our attention, saying "I've gotten some very positive local commentary—even from a Blue Shield official." It was originally published in the* Bulletin *in March 1994.*

Dear Mrs. Clinton:

I am a family practitioner and have been in practice here in my home community for the past 25 years.

The purpose of this letter is to tell you about Mrs. Glub's toenail. If someone screens your mail, they may not think this letter is very important, but let me assure them, it is important for Mrs. Glub.

Mrs. Glub came to my office a while back complaining that she had a very painful toe. "You have an ingrown toenail. Go home and soak it," I said. She replied, "I've been soaking it for two weeks. You've got to do something!"

"Come with me," I said, and escorted her into my surgical suite. Shirley prepared her, and I injected local anesthetic over the nerves supplying the toenail area. I then removed her entire nail, which provided immediate relief. She was amazed and very grateful.

Shirley sent a bill for $125.00 to Blue Shield of Northeastern Pennsylvania (Medicare). We subsequently received a check for $21.46. "There's got to be some mistake," I said. "Send an appeal." We then received a letter from the carrier that said: "We paid $21.46 because that is the rate."

After all of the above, a different Medicare patient came to my office with the same complaint. I said: "Yes, that is an ingrown toenail. I'll refer you to a specialist." We received $25 for that visit, and we subsequently learned that the podiatrist was paid $400 for removing the toenail.

I don't know if you talk about such health care delivery anomalies as this in Washington, but I thought someone should hear about Mrs. Glub's toenail.

Best wishes,

Edward A. Lottick, MD
Kingston

Your Letters Are Welcome

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Letters should be typed or legibly handwritten, concise, and should not exceed 200 words.

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Medical Assistance Plans Will Soon Blanket State

Fred Baldwin

Pennsylvania officials and physicians are piloting three alternative programs to the current Medicaid system in an effort to improve access to care and control rising costs. This article explores and compares the programs and their benefits.

Plans to launch three new programs for providing medical services to Pennsylvania's Medical Assistance (MA) patients are proceeding on schedule, according to officials at the Pennsylvania Department of Public Welfare (DPW). All three programs—each serving a different geographical area—will require MA recipients to choose a single provider for primary care, but they differ in significant ways.

The largest of the three in geographical coverage is the Family Care Network, which will serve children and youth under 21 years of age in 60 counties of the state on a fee-for-service basis. Almost as large in terms of eligible clients, HealthChoices will offer a choice among managed care plans to individuals of all ages within Philadelphia County and five adjacent counties—Berks, Bucks, Chester, Delaware, and Montgomery—which together contain roughly 40 percent of the state's MA recipients.

The smallest, but potentially most ambitious program, is the Lancaster Community Health Plan. Limited to Lancaster County, it will begin as a fee-for-service program for patients of all ages, and is later slated to include a comprehensive computer database and a managed care option.

Access, cost, and quality

Throughout most of Pennsylvania at present, individuals eligible for MA receive a card and a list of doctors in their areas who have previously billed for MA services. Clients have no guarantee, however, that doctors on the list are prepared to accept new patients. Moreover, the card is issued along with approval of other benefits, like cash assistance and Food Stamps, that are likely to be of more pressing importance to clients. Rather than finding a personal physician, many MA patients continue to rely on hospital emergency rooms for primary medical care.

DPW spokespersons say that improving the quality of medical care to MA patients is an even more important consideration than cost savings.

"Yes, there is a cost-savings aspect to this," says Frank Lentz, director, DPW Bureau of Special Medical Assistance Programs, "but the primary emphasis of the program from our standpoint is humanitarian. I know that sounds very self-serving, but I've heard so much that tends to imply that we're prepared to sacrifice thousands of clients to save a couple of bucks. I really need to stress that that's so far from our intention that it's almost ludicrous. There's so much that we can all do to improve the health quality of our clients, to prevent problems from happening, to keep them out of the hospital, and to get them in when they need it."

Currently, the department is responsible for paying for health care services for approximately 1.6 million MA recipients. The annual cost is more than $5.5 billion, which is more than 20 percent of the state budget. In the last four years, program costs have more than doubled.

DPW is under pressure to redesign its service delivery network as a result of a class action lawsuit filed in the U.S. District Court in Philadelphia by a number of Welfare rights and other advocacy organizations. The suit alleges that DPW's card-and-list approach does too little to help MA recipients take advantage of their rights to primary and preventive health care, particularly Early, Periodic, Screening Diagnosis and Testing (EPSDT) services for those under age 21, who comprise just under half of those who receive Aid to Families with Dependent Children (AFDC) benefits in Pennsylvania.

The litigation, which is still pending, involves other issues and names other state agencies as defendants. DPW, however,

Video Tape Promotes Lancaster Plan

In response to action by the 1993 House of Delegates, the State Society has prepared an informational video tape for county medical societies to promote the concepts behind the Lancaster Community Health Plan. The tape, which includes interviews with legislators and community leaders, was mailed to county societies in early May.

Mr. Baldwin is a contributing author from Carlisle.

believes that its new delivery system will blunt criticisms that it has been insufficiently aggressive on behalf of AFDC clients. The department also hopes its programs will enable it to stay a jump ahead of national health system reform efforts.

"I think this dovetails very nicely with President Clinton's proposals," says Lentz, speaking primarily of HealthChoices. "I think we're at least on the cutting edge, along with some other states."

Family Care Network

The Family Care Network (FCN), the 60-county program limited to under-21 patients, will work as follows. The program contractor is Automated Health Systems Incorporated, a Pittsburgh-based firm that has been providing management support for Early, Periodic, Screening Diagnosis and Testing. The contractor's first task is to recruit primary care providers, who may be either individual doctors, clinics, or hospitals. Providers receive $3 per month for each patient accepted in addition to the standard schedule of fees for service. Physicians decide for themselves how many MA patients they wish to accept: The maximum is 1,000 patients for a single physician or 5,000 for a site. These maximums may be waived if necessary to avoid disrupting existing patient-provider relationships.

Once enough providers have signed up, households and individuals eligible for assistance are contacted and encouraged to choose a provider from among those available. Clients who do not choose are assigned providers, but may change later if they wish.

Participating doctors and sites must provide primary care services, including EPSDT, and ensure 24-hour access to medical care. Although physicians receive lists of recipients who are assigned to them or who are disenrolled, they are responsible for verifying that patients are eligible for MA by dialing a toll-free number.

The providers also serve as gatekeepers for referrals. Specialists accepting referred patients will be paid according to the standard MA fee schedule; the program will not normally pay the costs of self-referrals from patients. Patients who show up at hospital emergency rooms with conditions that do not qualify for emergency care will be referred back to their FCN physicians. Patients who insist that a hospital provide non-emergency treatment are advised that they may be held responsible for costs.

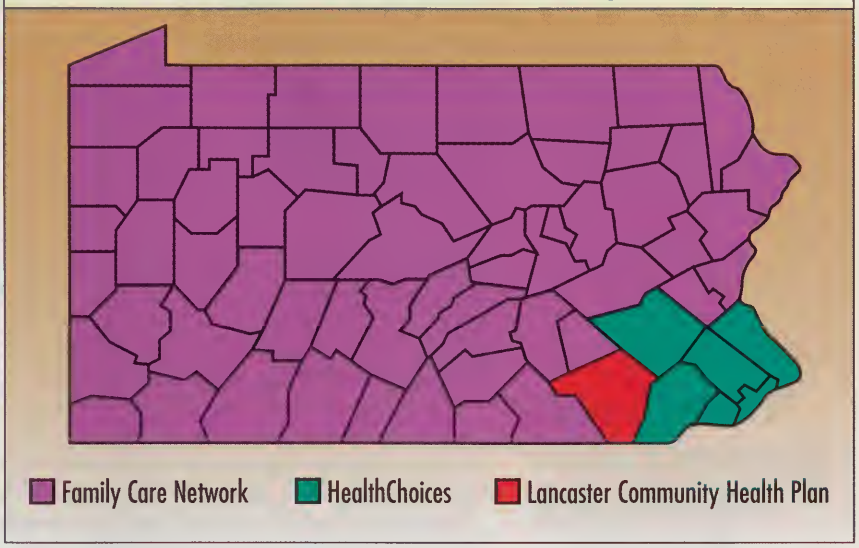
To test how its plans would be received, DPW began enrolling physicians in York County in December 1993. Dauvey Hoffman, FCN program manager, says she was encouraged that 60 physicians signed on promptly, including all hospitals and health centers. They made commitments to serve 28,000 patients, more than twice as many as needed for the county's 11,500 recipients. In February about half of the patients made their own selections of physicians; the rest were assigned physicians. The department is expanding the program to other counties, beginning with Erie, Washington, and Westmoreland, and hopes to have 72,000 patients assigned by the end of July and approximately 400,000 assigned by July 1995.

"Ultimately," says Hoffman, "we want each child to have access to a 'medical home'—primary and preventive medical care through a consistent source. The goal is a relationship to a physician so that families will feel comfortable going there and also stop going to an emergency room where no one knows them and where we have to pay a premium price for a condition that can be handled by a primary care provider. Although it's a cost-saving program, it's really designed to improve medical service delivery."

HealthChoices

HealthChoices, a mandatory managed care program, will serve MA recipients of all ages—roughly 650,000 living in its six-county area. It will replace an existing mix of fee-for-service arrangements, voluntary HMOs, and one mandatory managed care program now operating in southern and western areas of Philadelphia.

Geographical Coverage of Medical Assistance Plans in Pennsylvania



"The smallest, but potentially most ambitious program, is the Lancaster Community Health Plan."

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"I think this dovetails very nicely with President Clinton's proposals," says Lentz, speaking primarily of HealthChoices. "I think we're at least on the cutting edge, along with some other states."

The new program will divide the six-county area into three zones, each of which will be served by at least two HMOs. Each zone includes a portion of Central Philadelphia, where the concentration of MA clients is heaviest. This geographical division resembles three wedges of a pie, rather than a center-city bullseye surrounded by suburban rings.

This aspect of the plan has drawn criticism from some potential service providers (see "HealthChoices Under Fire," below), but the DPW position is that the three zones should be as similar as possible with respect to general demographics and caseload mix and, therefore, in attractiveness to insurers. All HMOs must guarantee that patients have access to providers no more than 30 minutes away in urban areas and no more than an hour away in rural areas.

DPW issued the technical portion of its request for proposals to potential contractors in February, followed by supplemental financial data in March. The department will reject bids priced higher than 91 percent of the costs of a fee-for-service program within each zone, based on existing caseload mix. Lentz says that an initial bidders' conference attracted 138 attendees, representing about 90 organizations. The schedule calls for selecting contractors during early summer and matching clients to plans by the end of this year.

As already noted, Lentz sees cost containment and access to quality health care as mutually complementary goals: "It's far better for the client, the managed care plan, and the taxpayers if they [the HMOs] manage that care by keeping people healthy [rather] than if they let things go until there's a problem that requires extensive correction. It's penny-wise, pound-foolish to withhold from someone a $1,000 treatment if a year from now they'd require a $10,000 treatment."

Lancaster Community Health Plan

The Lancaster Community Health Plan (LCHP) grew out of the work of a broad-based community task force—developed by the Lancaster City and County Medical Society and the Lancaster Business Plan on Health, and chaired by Robert Doe, MD, an emergency physician at Lancaster General Hospital and president of the county's medical society in 1992.

The plan was reviewed by the Pennsylvania Medical Society—which recommended some revisions and committed support to its further development—and in 1993, LCHP incorporated. It will begin to enroll providers toward the end of summer. Dr. Doe says that in an early survey, half of Lancaster County's approximately 600 physicians showed interest in enrolling.

LCHP initially will operate much like FCN, but is slated to add several features. Like the Philadelphia program, LCHP will cover all MA patients, not just those under 21. Doctors in a solo or small-group practice may choose to satisfy the 24-hour coverage provision through an arrangement with a local hospital emergency department. The emergency department personnel will perform triage and gatekeeping functions for a fixed rate. If the patient needs to see a physician, but the situation is not a true emergency, the hospital will charge a fee for an office visit.

HealthChoices Under Fire

In March, the Pennsylvania Health Law Project, the Hospital Association of Pennsylvania, and the Coalition of High Volume Medicaid Hospitals filed suit in Commonwealth Court seeking to block the Department of Public Welfare (DPW) from proceeding with implementing HealthChoices.

The plaintiffs contend that the plan could be disruptive to existing care relationships—those now receiving care from health maintenance organizations or from specific health care providers might be forced to switch depending on which firm gets the contract.

The suit also charges that the way DPW has structured the program by dividing Philadelphia into three separate zones will potentially have a negative effect on access to care. Further, the issue of public notice and lack of opportunity to comment through the administrative and regulatory processes has been raised in the complaint.

A preliminary hearing on the request for injunction was scheduled for May 18. At press time, the State Society's Legal Counsel was reviewing the complaint, and the Board of Trustees is considering the issue.

"Ultimately," says Hoffman, "we want each child to have access to a 'medical home'—primary and preventive medical care through a consistent source."

Work is also underway toward designing a computerized database called the Community Patient Information Network. Initially, the database will maintain basic information on LCHP patients to reduce local duplication of services and to simplify reporting to DPW. Later it will facilitate electronic billing, report writing, tracking individual patient problems, and tracking immunizations and well-child visits.

Finally, LCHP expects to negotiate with private insurance agencies in hopes that they will contract with DPW to provide managed care options both for MA patients and for other groups of uninsured and low-income workers. Ultimately, the "Lancaster Plan" envisions MA patients under the same umbrella—or, better, given the same choice among umbrellas—as the general public.

"We've all felt that you need to move toward a Philadelphia [managed care] model eventually," Dr. Doe says. "But you need time to learn how to manage this population and to provide an incentive for the providers to be involved. We believe that you should be mainstreaming these patients. What's the point in continuing Medicaid apart from the rest of the system? If I were a Medical Assistance patient, I'd like to be treated like any other patient, and the economies of scale can't be realized by creating duplicate networks."

He says that with slight variations, the Lancaster Plan may work in other counties, but notes that the key to such success is local flexibility: "Not every community will fit into one cookie cutter solution."

Another key to success, according to Dr. Doe, is physician involvement in such efforts. "It is extremely important for physicians to demonstrate our interest in our community, and it brings a lot of credibility to the physician population if you get involved, especially if the physician community takes the lead through the county medical society."

He adds, "The good faith and good feelings that come from such involvement begin to spread into other aspects of health care delivery and other aspects of the community health care system...It's a great way to be a part of the community."

LCHP has submitted to DPW a proposed contract outlining its program. Assuming there are no problems with the contract, or state funding for the contract, the program will begin operation in late summer or early fall.

Society Supporting Lancaster Plan

The Pennsylvania Medical Society in March 1993 affirmed its support of the development and testing of local networks—in particular, the Lancaster Community Health Plan (LCHP)—to deliver care in a coordinated system to Pennsylvania's Medical Assistance (MA) population.

The Society continues to support testing of the networks, and maintains that if LCHP is successful, it be used as a model for the development of other local networks across the commonwealth to serve the uninsured and underinsured, as well as MA recipients.

For more background on the Lancaster Community Health Plan and Dr. Robert Doe's involvement, see "Fighting the Access to Care Crisis," PENNSYLVANIA MEDICINE, February 1994, pp. 36-38.

For further information on the Society's position, call the Department of Regulatory Affairs and Specialty Legislation at (800) 228-7823 or (717) 558-7750.

Playing "Gotcha"

Mark W. Shulkin, MD

One Society member considers the ABCs of life, politics, and medicine.

"The EOB comes back with the printout, 'Payment is rejected because services were provided after the patient was deceased.'"

My BW (beautiful wife) took a gourmet cooking course from Joan Specter (Senator Arlen's BW). The cuisine at our house was so improved that I planned to invite the Specters over for dinner as a token of my gratitude and a demonstration of what a good teacher Joan was. That was 25 years ago when Arlen was still Philly's D.A. I'm such a terrible procrastinator that before I got around to calling Arlen, he got elected Pennsylvania's senator, and the Specters moved off to Washington.

Maybe this particular procrastination had something to do with the question, What do you talk about to lawyers like Arlen Specter over dinner? Lawyers are bored with the horror stories that doctors tell about dealing with insurance companies. Lawyers get indigestion when you bring up tort reform.

Then I got this great idea about entertaining Arlen with this fun game we doctors play with third party payers (TPPs). It's called "GOTCHA." If I ever get over my procrastination tendencies, I plan to invite Arlen to dinner so I can teach him how to play it.

I played a great game of GOTCHA last month.

I consulted for a 48-year-old patient (PT) at a nursing home (NH) early last year. She was there because she's quadriplegic due to multiple sclerosis (MS). I saw her again about a month later for follow-up.

Sometimes it pays to procrastinate

A dyed-in-the-wool procrastinator, I didn't get around to submitting my claim for the two visits until recently. That, incidentally, is not entirely dumb since procrastinating on submitting insurance claims gives other providers a chance to submit their claims first and to satisfy the yearly deductible for me.

Three weeks after I submitted my forms, the Explanation of Benefits (EOB) comes back with the printout, "Payment is rejected because services were provided after the patient was deceased."

Her death was exaggerated

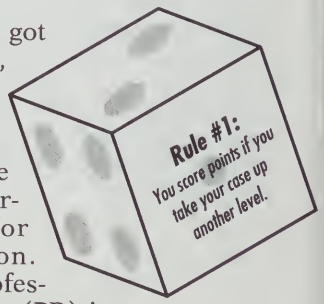
Curious, I called the NH to inquire about the circumstances of her demise, and I learned, to quote Mark Twain, that the rumor of her death was very much exaggerated. I made a toll call to the TPP's utilization review (UR).

After doing my time on hold, a very nice lady (VNL) explained to me that when a PT goes to a NH, their disability check is undeliverable to their home, and it gets returned to Social Security (SS). SS figures that the only reason anyone would return a check to them is because they are dead. Sounded reasonable to me.

"What should I do?" I asked the VNL at the other end of the telephone wire. She told me, "Resubmit with a note on the Health Care Financing Administration (HCFA) 1500 form stating that the PT is alive."

Computers don't read notes

I did what the VNL said and guess what happened. You're right! Three weeks later, my mailman (MM) brings me another EOB saying that the claim was rejected because the service was provided after the patient was deceased. Computers don't read notes.



By the time I got the second EOB, the year from date of service was approaching, setting me up for a 10 percent penalty for late submission. So I called Professional Relations (PR) instead of UR.

I forgot to point out that you score points in GOTCHA if you take your case up another level. You score more points if you use the initials for things, and your opponent doesn't know what they stand for.

Dr. Shulkin is a psychiatrist in Bala Cynwyd.

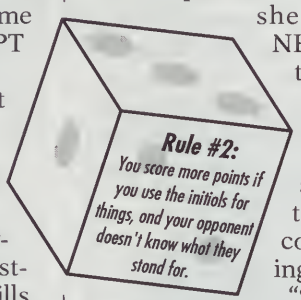
You lose points if your opponent uses initials, and you have to ask what they mean.

After doing my mandatory hold time, PR put me in touch with another VNL. This VNL efficiently looked the claim number up on her computer and told me that I could not be paid because the PT died in 1992.

I asked VNL why the TPP wasn't prosecuting me for submitting fraudulent claims. "GOTCHA," I thought.

The VNL said, "We don't do that because you wouldn't like that very much, and we're dedicated to improving PR." The game was getting interesting. This VNL was a match for my skills.

I explained about the returned disability check and SS's false assumptions that its return was indication of the PT's death. Could VNL correct the record?



BC in the sky

"Oh no!" said VNL. "That's the Big Computer (BC) in the sky. No one can change that. We have no access to it. There's nothing we can do." I thought I heard VNL whisper, "GOTCHA."

Turns out, VNL wasn't referring to the Deity in invoking the BC. SS in Baltimore keeps the records on its mainframe, and TPPs have no access to it.

"What do you suggest?" I countered. "Just forget about it?" (GOTCHA, I gloated.)

"Well, that's a thought," VNL mused. "None of the PT's doctors have been paid since 1992." She told me I had to get either the PT's relatives or the PT to call SS to verify that the PT was alive.

"But the reason the PT's in the NH is because PT has no relatives, and PT can't function for herself," I whined. Secretly I thought, "GOTCHA!"

"Then have the NH call SS to reprogram the BC," VNL warbled.

"But the NH doesn't work for me, and I can't assign work to the NH personnel. Besides that, the NH tried calling SS and didn't get any result," I rallied. I was about to get her.

I'll call them tomorrow

"Suppose I call the NH tomorrow and ask them to do it?" offered VNL.

I'm the expert on procrastination, so I said, "They're open today, VNL, why not call them now?" I gave VNL the phone number.

VNL called back a few minutes later and said that no one answered at the NH. She'd copied the number wrong. When she finally reached the NH, she called me back to say that she learned that SS had sent a representative to the NH two weeks ago, and SS had verified that the PT was to be counted among the living.

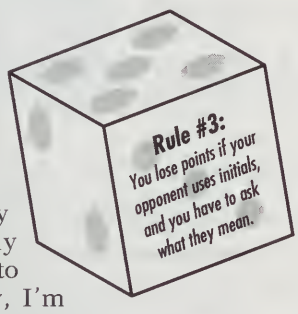
"So now I can resubmit HCFA 1500?" I ventured, tasting victory.

"No," replied VNL, "because BC hasn't been reprogrammed yet."

"When should I resubmit?" I queried.

"I can't tell you that," says VNL. "We never know when they'll reprogram BC. You'll just have to keep trying."

Playing trump



SS can procrastinate too, I reasoned, but I didn't give up. It was time to play my trump card!

"You've been very helpful, and I really appreciate it," I said to VNL. "By the way, I'm planning on inviting Senator Specter over for dinner, and I'll mention to him how helpful you were."

"GOTCHA" was my thought.

"You know," says VNL, "I'll leave this information on my desk and check my computer every day. When the change is made, I'll just have them send you the check without your having to resubmit the HCFA 1500 form."

"Thank you very much, VNL," I exuded. I soliloquized, "Victory is so sweet. I love this game."

As soon as I hung up, came the dawn! In VNL's handling my claim for me so expeditiously, I was going to be the first and only doctor to satisfy the PT's deductible for 1993. Eighty percent of two consultations at $61.21 each would amount to less than the $100.00 deductible. I would get exactly nothing! GOTME!

Tracking Family Practice Graduates

John R. Tyler, MD

Lancaster General Hospital in 1991 surveyed graduates of its 21-year-old Family Practice Residency on a number of medical and non-medical issues. The results, overviewed in this article, may lay the groundwork for future efforts to obtain a national consensus regarding family practice education in its current format.

The Lancaster General Hospital (LGH) Family Practice Residency, one of the country's earliest such programs, accepted its first residents in July 1970. Today, it continues to prosper, having graduated 196 well-trained family physicians, almost all of whom are practicing in the U.S. The program regularly tracks its graduates to assess the perceived quality of the training program in preparing graduates for practice, as well as determining the nature and satisfaction of graduates' jobs.

Earlier surveys have evaluated practice patterns[1-4] and job satisfaction[5-6] following family practice residency education, but in anticipation of the program's twenty-first anniversary celebration, all graduates were surveyed regarding education/practice, practice location, hospital- and office-related issues, work week, non-practice-related activities, professional activities, training, and practice satisfaction. Virtually every graduate year was represented equally in survey responses.

Demographics

Seven respondents had obtained additional education and were presently active in another specialty: three in psychiatry, two in dermatology, one in obstetrics, and one in acupuncture. Three graduates with no additional residency training are practicing emergency medicine.

Nearly 40 percent of LGH residency program graduates have established practice sites within Lancaster County. Twenty percent more have remained in Pennsylvania, and another 20 percent practice throughout the Northeast. Others are scattered throughout the U.S., including Hawaii and Alaska; missionaries are serving permanent assignments in Africa and the Philippines.

Respondents are equally distributed throughout rural, semi-rural, suburban, and urban locations, though these descriptions were not qualified.

Practice patterns

A majority of respondents (83 percent) identified hospital practice as a part of their business. A similar majority (82 percent) did not offer obstetrical delivery as a service.

Obstetrical practice patterns among family practice physicians in the Southeastern U.S.[7] and specific to Pennsylvania[8] have previously been investigated. It is notable that until 1989, LGH obstetricians provided the bulk of the curriculum in this field. Since that time all additional family practice faculty joining this program (five) include obstetrics in their practice.

By bringing these skills to their role as educators, full family practice OB coverage now exists with obstetrical specialists serving the role of consultant. The influence of this family physician role modeling on future graduates remains to be seen, but undoubtedly affected the decision of one-half of the 1992 and 1993 graduates to include obstetrics in their practice plans.

Also, group practice was much more popular than solo (102 vs. 22), and virtually every respondent used a computer for business efficiency, and 50 percent used transcribed office notes.

Professional activities

A large majority of the respondents listed interest in regional, specialty-specific politics, such as state and local chapters of the American Academy of Family Physicians (86 percent) and local medical societies (52 percent). Participation in national organizations was less represented (AMA, 39 percent; Society of Teachers of Family Medicine, 13 percent; Physicians for Social Responsibility; eight percent).

Dr. Tyler is director, Walter L. Aument Family Health Center, a division of Lancaster General Hospital, Quarryville.

The stimulus to maintain current clinical information provided during graduate medical education, previously referred to as "intrinsic audit,"[9] is followed variably by outside sources, including journals (64), lectures/conference (41), continuing medical education courses (56), and consultants (9).

Training program

With the perspective of time and experience, an overwhelming majority of LGH graduates described the amount and type of training received during their residency years as "appropriate" and "about right." The few exceptions were in the areas of: office management, "need much more" (76); cardiology training, "excessive" (20); and obstetrics, "excessive" (15).

The majority of negative cardiology comments were from graduates prior to 1989, and the majority of negative obstetrics comments were from more recent graduates, corresponding to major curriculum changes that year, increasing time devoted to obstetrics and moving time in cardiology to a more general internal medicine focus. Fewer disappointments were noted by more recent graduates when compared to the '70s graduates.

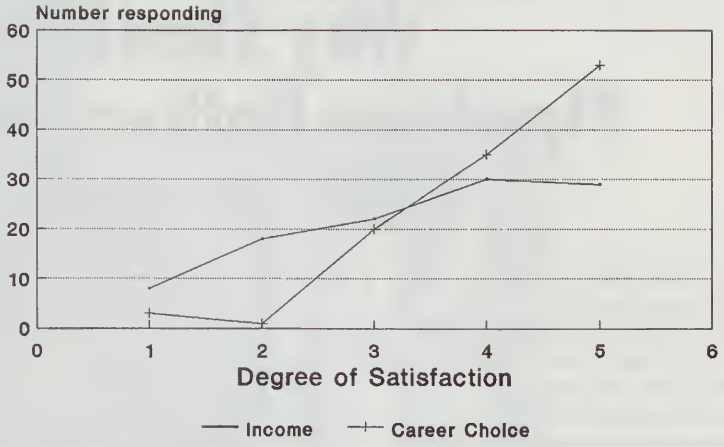
On a scale of one to five, respondents valued career choice far higher than satisfaction with current income (see table, above, right). Answers to questions regarding lifestyle and on-call obligations demonstrated no consistent pattern.

This survey of one of the largest single family practice residency graduates groups in Pennsylvania affords an opportunity to review the perceptions of students with the perspective of time and experience. Curriculum modifications that will fulfill the roles desired by this group will best be made guided by report cards such as this document.

The statistical significance of the responses summarized here would be enhanced by a future effort to survey multiple programs, eliminating some of the parochial bias inherent in this effort. Finally, the fact that this survey garnered a 71 percent response rate despite its six-page length underscores the importance this group assigns to data collection perceived to have potential future impact on positive change. ○

References available upon request.

PRACTICE SATISFACTION



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Why Should the Physician Bother with CMNs or Orders?

Medicare Part B has been expending vast sums for durable medical equipment used in the home—prosthetics, orthotics, and various supplies (parenteral and enteral nutrition, dialysis, dressings, etc.). To ensure proper utilization, Medicare has now established Durable Medical Equipment Regional Carriers (DMERCs) to administer claims for items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Designating carriers that deal only with these items will result in increased efficiency and expertise in claims processing and adjudication. Creating only four regional DMERCs for the entire nation will lead to more consistent medical policy development and format. Ultimately, this should translate into savings for the Part B Medicare program.

While the physician's authority has been gradually eroded over the years, with many other health-care professionals filling various patient needs in the hospital, home, and community, the DMERCs have insisted on deferring to and maintaining the proper role of the physician as the leader of any health care team. It is the physician who should be signing off on the necessary items of DMEPOS, and not only the supplier and Medicare.

Physicians are also reimbursed from Medicare Part B funds. In this time of ever-decreasing national fiscal resources, it is in the physicians' interest to take an active role in overseeing the proper utilization and distribution of DMEPOS items, which represent a substantial proportion of Medicare payments.

In order to accomplish this oversight and control function, physicians are asked to merely review and sign their orders to suppliers, and similarly for the Certificates of Medical Necessity (CMNs) for prosthetics, orthotics, and supplies. (CMNs for items of durable medical equipment require partial completion by the physician, along with his/her signature.) Although this may at first seem to be just another burden, consider this scenario: If a physician writes a prescription for a "wheelchair," without any added details about wheelchair type or accessories, a wheelchair worth approximately $25,000, or even an electric wheelchair worth nearly $40,000, might be supplied, when a far less costly item could have served equally well.

Only the attending or consulting physician is in a position to know the needs of his or her patient. Allowing DMEPOS suppliers to take verbal/telephone orders, and write them down for the physician, while requiring only the physician's signature verification, encourages dialogue between the two. While the physician knows the patient's condition, the supplier can explain the purpose of the various available features that he or she feels are appropriate. The suppliers maintain the DMERC medical policies and should know the proper indications for levels of equipment. This can prove an educational experience for physicians, as well as ensuring that the patient is issued only that which is needed.

Finally, if a supplier must abandon the attempt to obtain a properly physician-completed or punctually returned CMN, the patient will end up paying for the needed medical equipment. This would be an unfortunate hardship on a patient whom the doctor is otherwise trying so hard to serve, and who otherwise would have been entitled to this Medicare benefit.

Please consider all these points when you are asked to deal with a CMN or order for DMEPOS items. We physicians have traditionally asserted our proper role as the patients' medical guardians. We would never consider having anyone other than physicians write orders for our patients in the hospitals or our offices.

We have been trained to write precise prescriptions based on our scientific knowledge and years of acquired clinical judgment. Why would we allow anyone other than ourselves to fill this role when it comes to medical equipment?

The author, Paul D. Metzger, MD, is consultant to the medical director, The Travelers Medicare DMERC Region A, Wilkes-Barre.

PATIENT ENROLLMENT IN MANAGED CARE INCREASING

While enrollment in managed care plans is increasing, many people have very little information about plan features when they enroll, according to a Gallup Survey done for the AMA.

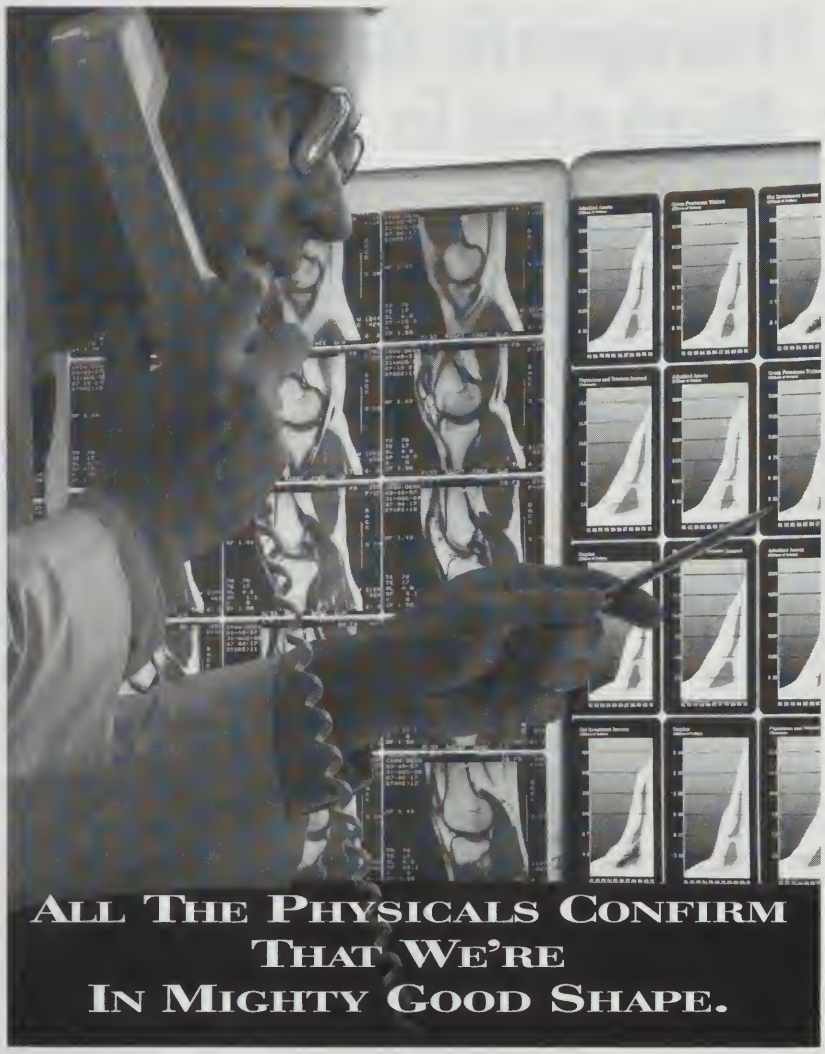
The telephone survey was of 3,540 randomly selected adult household heads, 2,153 of whom reported being employed and covered by insurance other than Medicare or Medicaid. Of those, 743 reported being enrolled in managed care plans.

Gallup says that the number of households enrolled in managed care plans—21 percent of all households and over 35 percent of those employed—suggests growth in managed care enrollment.

Those most likely to be in managed care were aged 25-44 years, African-Americans, and more often living in the West. There was also a direct relationship between household income and managed care enrollment: 29 percent of households making under $25,000 per year were in managed care, while 39 percent of those making $75,000 or more were not.

DPW To Process Medicare Crossover Claims

The Pennsylvania Department of Public Welfare (DPW) has announced that Medicare Part B Crossover processing of claims will begin on June 6, 1994. Claims submitted to the Medicare carriers, Pennsylvania Blue Shield and The Travelers, for individuals with dual coverage of Medicare and/or railroad retirement coverage and Medical Assistance, will automatically be sent to DPW for further payment processing. A *Medical Assistance Bulletin* will be issued to inform providers of the Medicare Crossover process.



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New Therapeutic Agents Marketed in 1993

This is the third in a series of articles overviewing new drugs marketed in the U.S. in 1993.

Daniel A. Hussar, PhD
Remington Professor of Pharmacy
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In 1993, the Food and Drug Administration (FDA) approved 25 new molecular entities (NMEs), 23 of which are for therapeutic use and two are diagnostic agents. Eleven of the NMEs for therapeutic use, as well a new biological agent intended for therapeutic use, were both approved and marketed in the United States in 1993. In addition, 11 other NMEs that the FDA approved before 1993 (most in late 1992) were marketed during the year. Thus, a total of 23 therapeutic agents reached the U.S. market for the first time in 1993, a considerably lower number than the 30 new therapeutic agents marketed in 1992 and the record number 31 new agents marketed in 1991. Many of the 13 therapeutic agents approved in 1993 but not marketed before the end of the year have become available in early 1994.

Of the 23 new therapeutic agents first marketed in 1993, 22 are considered in this series. The one agent not reviewed is flosequinan, which was withdrawn from the market after being available only several months because of a concern about toxicity.

This review considers the new agents' most important properties and, when possible, compares them with other available agents with similar properties. When additional information is needed, more comprehensive references and the product literature should be consulted.

Agent for metastatic bone pain

Strontium-89 chloride (Metastron-Medi-Physics; Zeneca) is a radiopharmaceutical that decays by beta emission. Following intravenous administration, it selectively concentrates in bone mineral and its uptake by bone occurs preferentially in sites of active osteogenesis. Therefore, primary bone tumors and areas of metastatic involvement can accumulate significantly greater concentrations of strontium than surrounding normal bone. The drug has minimal effect on normal bone and surrounding tissues.

Nearly 50 percent of individuals with prostate or breast cancer eventually develop bony metastases which may result in severe and unremitting pain. It is estimated that as many as 100,000 cancer patients suffer from painful bony metastases for which treatment often involves the use of high doses of opioid analgesics. Strontium-89 is indicated for the relief of bone pain in patients with painful skeletal metastases and represents an important alternative for cancer patients whose pain is not adequately controlled with conventional analgesic regimens or who experience unacceptable adverse reactions with these agents. The new drug improved pain control in about 75 percent of the patients in the clinical studies and, in one study, 20 percent of patients with advanced prostate cancer experienced complete pain relief. In addition to providing pain relief and reducing or eliminating narcotic requirements, strontium-89 may also delay or reduce the number and size of metastatic sites and time to pain recurrence.

A single dose of strontium-89 provides long-term pain relief for an average of six months. The onset of pain relief is typically delayed, often occurring seven to 20 days after injection. During the first week after the injection, patients may actually experience a transient increase in pain. This "flare reaction" usually lasts from two to four days and can generally be managed by increasing analgesic medications during this time period.

Strontium-89 suppresses the bone marrow, particularly the white blood cells, which fall by about 20 percent, and platelets, which are depressed by about 30 percent. Recovery occurs slowly, typically reaching preadministration levels three to six months after administration of the drug. It is recommended that peripheral blood cell counts be monitored at least every two weeks. When the drug is used in combination with cytotoxic agents, the additive toxicity to the bone marrow should be considered.

Strontium-89 may cause fetal harm when administered during pregnancy and is classified in Pregnancy Category D. Women of childbearing potential should be advised to avoid becoming pregnant.

Because strontium-89 follows the same metabolic pathways as calcium, there is a potential for a competitive interaction between the two agents at the sites of bone turnover. As a precautionary measure, patients should discontinue calcium medications for about two weeks prior to receiving strontium-89.

The beta emissions from strontium-89 have a range of approximately 8 mm in soft tissue and cannot travel out of the body. The risk to health care personnel and household contacts is minimal; nevertheless, like other radioactive drugs, strontium-89 must be handled with care and appropriate safety measures taken to minimize radiation risks. The drug is administered by physicians who are licensed to handle radiopharmaceuticals. Because the level of radioactivity is very low, patients can interact with family members and engage in normal daily activities.

Strontium-89 is usually administered on an outpatient basis. The recommended dose is 4 mCi, administered by slow intravenous injection over one to two minutes. More rapid injection (i.e., less than 30 seconds) may result in a flushing sensation. Repeated administrations of the drug should be based on the patient's response to therapy, current symptoms, and hematologic status, and are generally not recommended at intervals of less than 90 days.

Strontium-89 chloride is supplied in a 10-ml vial containing 4 mCi of the drug.

Agent for opiate dependence

Levomethadyl acetate hydrochloride (ORLAAM-BioDevelopment), also known as levo-alpha-acetylmethadol hydrochloride (LAAM), is a synthetic opiate agonist that is structurally related to methadone (Dolophine). LAAM is the designation for the new agent that has been used most commonly and that will be employed in this discussion.

Although LAAM exhibits the analgesic and other actions that are characteristic of the opiate agonists, the specific indication for its use is the management of opiate dependence, and it is dispensed only by treatment programs approved by the FDA, the Drug Enforcement Administration, and the designated state authority.

LAAM acts via two mechanisms in the management of opiate abuse. First, it cross-substitutes for opiates of the morphine-type and suppresses symptoms of withdrawal in opiate-dependent individuals. Second, chronic oral administration of LAAM can produce sufficient tolerance to block the subjective "high" of usual doses of parenterally administered opiates.

LAAM undergoes first-pass metabolism to its demethylated metabolite nor-LAAM, which is sequentially N-demethylated to dinor-LAAM. These metabolites are also opioid agonists and are more potent than the parent drug. The opioid effect which occurs when

LAAM is administered is slower in onset (two to four hours) and longer in duration (48 to 72 hours) than that of methadone (usual duration of 24 hours). The long duration of action of LAAM permits three-times-weekly administration that eliminates the need for daily clinic attendance for the administration of methadone and/or the need for take-home medication, the major source of street methadone diversion. Investigators have reported that some patients treated with LAAM may experience less variation in opioid effects and have less drug craving than with methadone.

The slow onset of action of LAAM makes it less subject to abuse by addicts seeking an immediate "high." In addition, because LAAM requires biotransformation in the liver to exert its full clinical effects, it acts more quickly when taken by mouth than if it was injected, thereby reducing its potential for intravenous abuse.

LAAM is intended for use as part of a comprehensive treatment plan that also includes appropriate medical evaluation, treatment planning, and counseling. The therapeutic goal early in treatment is to reduce illicit opioid use, and the new agent was found to be comparable to treatment with methadone in attaining this goal in the controlled clinical trials. The use of LAAM or methadone in the treatment of opiate dependence is employed with the hope that it will eventually be possible to discontinue the use of the narcotic; however, for many individuals this hope is not fulfilled, and treatment is continued indefinitely.

Like the other opiate agonists, LAAM may cause central nervous system effects, and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Although most patients do not experience such impairment, patients treated with LAAM should be warned not to engage in such activities if their alertness and behavior are affected, and also about the risk of interactions with other central nervous system (CNS) depressants including alcohol. Tolerance and physical dependence will develop upon repeated administration and, because of its potential for abuse, LAAM is classified in Schedule II under the Controlled Substances Act.

LAAM is usually administered three times a week, either Monday-Wednesday-Friday or Tuesday-Thursday-Saturday. These two schedules include a 72-hour inter-dose interval following the Friday and Saturday doses, respectively. If withdrawal is a problem during this longer interval, the dose administered prior to the 72-hour interval may be increased, or small supplemental doses of methadone may be given. In some cases, an every-other-day schedule may be preferable. LAAM must not be used on a daily basis, and usual doses must not be given on consecutive days because of the risk of overdose.

Because of LAAM's slow onset of action, patients will not feel the full effects of the medication for at least several days, and they should be warned that the use or abuse of other psychoactive drugs, including alcohol, may result in serious, and even fatal, complications. Patients must also understand the importance of complying with the dosage regimen and that the drug should not be used on a daily basis because of the risk of excessive accumulation and overdosage.

LAAM is supplied in an aqueous solution containing 10 mg of the drug per ml. This solution should always be diluted before administration and should be mixed with diluent prior to dispensing. To avoid confusion between prepared doses of LAAM and methadone, the liquid used to dilute LAAM should be a different color from that used to dilute methadone in any specific clinic setting.

Antihistamine

Loratidine (Claritin-Schering) joins terfenadine (Seldane) and astemizole (Hismanal) in a group of antihistamines that are considered to be nonsedating. Although structurally related to azatidine (Optimine), the new agent more selectively antagonizes peripheral histamine H_1-receptors and is not likely to cross the blood-brain barrier and cause central nervous system effects (e.g., drowsiness, dizziness) or anticholinergic effects. Loratidine is indicated for the relief of nasal (e.g., runny nose) and non-nasal (e.g., itchy eyes) symptoms of seasonal allergic rhinitis (hay fever). In the clinical trials, it was demonstrated to be as effective as clemastine (Tavist) or terfenadine in relieving the symptoms of allergic rhinitis.

The adverse reactions most commonly reported with the use of loratidine in the clinical studies include headache (12 percent), somnolence (eight percent), fatigue (four percent), and dry mouth (three percent). However, the incidence of these effects was similar in patients receiving placebo.

It has recently been recognized that terfenadine and astemizole have the potential to cause serious cardiovascular effects, including torsades de pointes and other ventricular arrhythmias, although such reactions have been reported very infrequently. These reactions have been associated with elevated concentrations of the antihistamines that could result from use of higher-than-recommended doses, slower metabolism due to significant hepatic dysfunction, and/or interactions with other drugs such as ketoconazole (Nizoral), itraconazole (Sporanox), erythromycin, and clarithromycin (Biaxin), which may inhibit the metabolism of the antihistamine. The increased concentration of the antihistamine may lead to prolongation of the QT interval and associated complications.

To date, there have been no reports of torsades de pointes type of arrhythmias in the experience with loratidine and, in one study in which loratidine was administered in a dose (40 mg) that is four times that which is currently recommended for a period of 90 days, there was no significant QT prolongation seen on the electrocardiograms (ECGs). Although such a reaction with the use of loratidine cannot be excluded, the new drug appears to be less likely than terfenadine and astemizole to be implicated in these problems.

Loratidine undergoes extensive first-pass metabolism and is primarily converted to an active metabolite, descarboethoxyloratidine, which has a longer elimination half-life than the parent compound. Food has been reported to delay the time to peak plasma concentration; it is, therefore, recommended that loratidine be administered on an empty stomach.

The concomitant administration of ketoconazole has been reported to increase the plasma concentration of loratidine and its active metabolite. However, no changes were noted on the ECGs, and there were no significant differences in clinical adverse events between loratidine groups with or without ketoconazole.

The recommended dosage of loratidine in adults and children 12 years of age and older is 10 mg once a day on an empty stomach. Astemizole is also administered once a day whereas terfenadine is usually administered twice a day. The antihistaminic action of loratidine begins within one to three hours after administration, reaches a maximum at eight to 12 hours, and lasts longer than 24 hours. The prompt onset of action of loratidine provides an advantage over astemizole which has a slow onset of action that may result in a delay in reaching its maximum effect. When astemizole therapy is discontinued, the action of the drug persists for an extended period of time, and the continued action of the drug must be recognized if allergen skin tests are to be conducted. However, after cessation of loratidine treatment, there is not a prolonged suppression of allergen skin testing.

Loratidine tablets are supplied in a 10-mg potency.

Are Broad-Spectrum Antibiotics the Best Choice?

Based on efficacy and safety, most patients with common infections like otitis media, sinusitis, bronchitis, and pharyngitis do not require new broad-spectrum antibiotics such as Augmentin (amoxicillin/clavulanate), Ceclor (cefaclor), Ceftin (cefuroxime), or Suprax (cefixime) as initial therapy. Diarrhea, gastrointestinal distress, and yeast infections are common side effects of broad-spectrum antibiotics. Frequently, other agents will cure the patient at a fraction of the cost.

Otitis media

Based on efficacy and safety, amoxicillin is the drug of first choice for the treatment of acute otitis media. Most patients respond to this treatment. An uncommon exception to this rule is the treatment of a suspected resistant organism. If there is suspected resistance, consider: Bactrim (trimethoprim/sulfamethoxazole), Pediazole (erythromycin/sulfisoxazole), Ceclor, Augmentin, Ceftin, or Suprax.

Sinusitis

Acute, uncomplicated sinusitis is most commonly caused by organisms typically sensitive to amoxicillin. However, if there is suspected resistance, consider: Bactrim, Ceclor, Augmentin, or Lorabid (loracarbef).

Bronchitis

Acute bronchitis in a non-smoker under age 45 is usually due to a virus and is occasionally caused by *Mycoplasma pneumoniae*. Appropriate therapy includes no prescription drug therapy (for viral infections) or E-Mycin (erythromycin).

Acute bronchitis in those over age 45 or among smokers is most commonly caused by organisms typically sensitive to amoxicillin such as *H. influenzae* or *S. pneumoniae*. Those who have chronic obstructive pulmonary disease may also be commonly infected with *B. catarrhalis*, which responds to Achromycin (tetracycline) or Bactrim.

Pharyngitis

Acute, uncomplicated pharyngitis is most commonly caused by a viral infection, and patients will not benefit from antibiotic therapy. In contrast, patients with Group A beta-hemolytic streptococcus (strep throat) should be treated with an antibiotic such as penicillin to prevent the complication of rheumatic fever. Broader-spectrum antibiotics are no more effective than penicillin in treating strep throat. If there is a known or suspected allergy to penicillin, consider: E-Mycin, Biaxin (clarithromycin), or Zithromax (azithromycin).

A note on costs

For most common infections, broad-spectrum antibiotics are neither superior nor required, and cost much more than other available antibiotics. Sophisticated, expensive antibiotics are becoming first-line therapy, even where they may be unnecessary or insufficient treatment.

A list of commonly prescribed antibiotics and their costs is provided in the chart on the next page. For a free pocket card or wall chart version of this information, contact the Society's Center for Professional Drug Education and Information at (800) 228-7823 or (717) 558-7750. Pocket cards and wall charts are also available on nonsteroidal anti-inflammatory drugs and quinolone antibiotics.

Sources available upon request.

HID NAMED PARTNER IN DUR PROGRAM

The federal Omnibus Budget Reconciliation Act (OBRA) of 1990 requires each state to develop a comprehensive drug use review (DUR) program for its Medical Assistance (MA) program. The core of this requirement involves educational outreach activities that are designed to promote medically appropriate and cost-effective prescribing, dispensing, and utilization of prescription medications.

The Pennsylvania Department of Public Welfare (DPW) has contracted with the Pennsylvania Medical Society to manage educational outreach activities under the Pennsylvania Medicaid Retrospective DUR Program. The Society's Department of Professional Drug Education and Information was created to implement this contract. DPW has also contracted with Health Information Designs, Inc. (HID), a firm with many years of experience in DUR, to work with the Society on this program.

In addition, DPW has established a DUR Board, composed of Pennsylvania-licensed physicians and pharmacists, to provide oversight and expert clinical input concerning this DUR program.

The Pennsylvania Retrospective DUR Program will have two basic components: one focused on the drug utilization of individual Medicaid recipients, and a second oriented toward the prescribing habits of physicians.

Recipient profiles

The recipient-specific monitoring program is often referred to as "therapeutic drug utilization review." The goal is to communicate with providers about drug therapy regimens of individual Pennsylvania Medicaid recipients which appear to place specific Medicaid recipients at clinically significant risk for drug-induced illness or other adverse outcomes.

The review process consists of six basic steps:

1) update recipient drug and medical claim histories*;

2) perform computer analysis of recipient histories using clinically based, peer-reviewed therapeutic criteria*;

3) generate "profiles" for recipients who except under one or more therapeutic criteria*;

4) review of profiles by specially trained pharmacists to confirm their clinical significance*;

5) review of profiles by DPW staff and the Society's clinical staff and physician advisors; and

6) mail alert letters and copies of recipient profiles to the physician(s) who prescribed the drugs involved in the potential problem therapy. The letters are intended solely to provide the treating physicians with information to be used at their discretion in the ongoing care of the Medicaid recipient. A postage-paid reply envelope is included with each letter for the physician to use in making a voluntary response or to seek additional information from the DUR program's clinical staff.

Physician profiling/education

This retrospective DUR program component provides physicians with clinically oriented, unbiased education concerning classes of medications. Under this program, physicians' Medicaid prescribing records will be analyzed periodically using a series of clinically based criteria. These criteria will encompass tests for the medical appropriateness and cost effectiveness of prescribing for several key therapeutic drug categories.

HID generates profiles for each physician who may benefit from education about one or more drug classes. These profiles are reviewed by licensed physicians and pharmacists to confirm their clinical significance. The Society will offer physicians education on these classes of medication through various methods, including mailed materials and face-to-face discussions.

The key focus of both of these DUR program components is to provide physicians with information that will allow them to make more fully informed decisions in caring for Pennsylvania Medicaid recipients.

Opportunities for physician input

Physician input is critical to the ongoing success of this type of program. We encourage you to call or write with your comments and suggestions. We hope that you will use the response mechanisms included with each educational intervention to provide the Society with your reactions to this program.

The Society and HID will also be scheduling a series of workshops around the commonwealth to give you an opportunity to learn first hand how the program works. We look forward to seeing you at one of these workshops.

**performed by HID*

Natalie A.Harley, director of the Society's Department of Professional Drug Education and Information, contributed to this page.

Antibiotic Therapy: Cost of 10 Days for an Adult Patient

BRAND NAME	GENERIC NAME	ADULT DOSING	QUANTITY	BRAND COST	GENERIC COST
Achromycin	Tetracycline	250 mg QID	40	$ 3.91	$ 4.27
Amoxil	Amoxicillin	500 mg TID	30	$ 15.12	$10.74
Bactrim DS	Trimethoprim/ Sulfamethoxazole	160 mg/ 800 mg BID	20	$ 20.73	$ 8.75
E-Mycin	Erythromycin	250 mg QID	40	$ 12.20	$ 8.70
Pen-Vee-K	Penicillin V Potassium	250 mg QID	40	$ 6.08	$ 5.13
Alternative Therapies:					
Augmentin	Amoxicillin/ Clavulanate	500 mg TID	30	$ 74.75	NA
Biaxin	Clarithromycin	250 mg Q12	20	$ 48.01	NA
Ceclor	Cefaclor	250 mg TID	30	$ 60.38	NA
Ceftin	Cefuroxime	250 mg BID	20	$ 61.20	NA
Cipro	Ciprofloxicin	500 mg BID	20	$ 61.45	NA
Lorabid	Loracarbef	400 mg Q12H (2 CAPS)	40	$123.96	NA
Suprax	Cefixime	400 mg QD	10	$60.15	NA
Zithromax**	Azithromycin	250 mg QD	6	$44.05	NA

Notes

Cost = Average wholesale price plus $3.00 dispensing fee.
Dosage and duration may have to be adjusted for disease severity, age, and/or co-morbid conditions.
NA = not available.
** = 5 days of therapy.

This comparative table was assembled by Health Information Designs, Inc. (HID)—a firm specializing in drug utilization review, based in Fairfax, Virginia—who is a partner in the Pennsylvania Medicaid Retrospective DUR program. Copyright 1993, The Prescription Drug Education Project.

Source

1993 Red Book Drug Topics Update. Medical Economics Company, Oradell, New Jersey.

Governmental Antitrust Policy: Soon Obsolete?

Leo Uzych, JD, MPH

Six antitrust enforcement policy statements issued in 1993 raise many valid concerns for physicians. This article describes and analyzes two of those statements most important to '90s physicians.

Physician efforts in the past to construct networks have been impeded in part by wide-ranging concerns that such endeavors may run afoul of extant antitrust laws. Although the body of antitrust law does not entirely cut off the flow of physician-organized networks, these laws do limit the contours of lawful organizations.

Statements of Antitrust Enforcement Policy in the Health Care Area, issued in September 1993 by the U.S. Department of Justice and the Federal Trade Commission, are broadly intended to provide education and instruction to the health care community regarding antitrust enforcement policies affecting mergers and various joint activities in the health field. The six policy statements are similarly designed to assuage gnawing feelings of antitrust uncertainty which may otherwise impede cost-conscious mergers and joint ventures. Guidance is provided in the form of so-called "antitrust safety zones," which etch the boundaries within which the pertinent governmental agencies will not challenge conduct as allegedly violative of applicable antitrust strictures.

The present time, of course, is one of great uncertainty in the health area. Indeed, President Clinton has drafted a plan for health reform broadly comprising "health alliances," and which augurs substantially embellished governmental control over health care financing and delivery. If a health care system tightly regulated by the government in fact comes to pass, then the recently promulgated Statements of Antitrust Enforcement Policy may rapidly become atavistic. Yet, their present existence raises concern to physicians.

Mr. Uzych is an attorney specializing in health law based in Wallingford.

Physician network joint ventures

One of the statements pertains particularly to enforcement policy affecting physician network joint ventures. As defined in the policy statement, a "physician network joint venture" is a physician-controlled venture that markets jointly the services of member physicians. An introduction to the statement points out that such entities, because of their potential for providing quality services at reduced prices, contain the seeds of "significant procompetitive benefits" for medical consumers.

The policy statement then sketches an "antitrust safety zone," describing physician network joint ventures that will not be challenged, absent "extraordinary circumstances," by the government. The safety zone reaches to physician network joint ventures comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share "substantial financial risk." This safety zone is applicable equally to "exclusive" physician network joint ventures, which "significantly" restrict the ability of members to affiliate with other physician network joint ventures and contract individually with health insurance plans, and "non-exclusive" physician network joint ventures, which do not impose significant restrictions on members desiring to contract with other entities.

As the swelling wave of health system reform descends, it almost certainly will encompass the theory of managed competition. The efficacy of the size limitations imposed by the antitrust safety zone for physician network joint ventures will be affected by whether, and to what degree, the limits mesh with the practical realities enveloping managed competition.

Data presented last year in a *New England Journal of Medicine* article† suggest that the limits may mesh poorly with such realities. The authors assumed ("somewhat arbitrarily") that at least three health

plans are needed to support "healthy competition." Based in part on this assumption, they estimated that at least 1.2 million persons would be required to support three HMOs capable of providing almost all services. However, only 42 percent of the U.S. population resides in markets with populations of more than 1.2 million.

This example indicates that the size limits mandated by the antitrust statement will make it quite difficult to construct qualifying networks in the more sparsely populated parts of the country. Generally, the economic efficiency of a network will increase as the number of patients increases, which in turn will require an increase in the number of physicians to provide needed services. In smaller population centers, it may not be possible for a network to assemble a sufficiently large number of physicians and still fall within the size limits mandated by the antitrust statement.

The 20 percent size limit is plainly a thorn in the flesh of physician networks: "Non-exclusive" networks cannot readily seize market power or artificially raise prices, whereas an "exclusive" network may be empowered to exert market power and raise prices.

One possible solution is to create two size limits: a higher size limit for non-exclusive networks, and a smaller size limit for exclusive networks. This type of two-layered mechanism may facilitate the development of networks even outside major urban areas.

Physicians' provision of information to purchasers of health care services

Another of the recently issued statements establishes an antitrust safety zone describing collective physician provision of information that will elude antitrust challenge, absent extraordinary circumstances. In particular, the zone provides that physicians' "collective" provision of "underlying medical data" that may "improve" purchasers' resolution of issues relating to the "mode, quality, or efficiency" of treatment is "unlikely" to raise any "significant" antitrust concern.

The statement, however, provides specifically that the antitrust safety zone does not extend to physicians' "collective" provision of "fee-related" information to purchasers. A stated rationale for this posture is that such conduct can raise antitrust concerns to the extent that it "signals or facilitates" physicians' "collective price demands." Thus, competing physicians who seek to negotiate fees with a purchaser run a "substantial" antitrust risk and an "even greater" risk if they "implicitly or explicitly" threaten to boycott or actually boycott a purchaser not willing to acquiesce to "suggested" fees.

The wisdom of this safety zone, in some respects, is open to question. Existing case law recognizes that collective development of fee-related information by physicians does not necessarily constitute an antitrust violation, especially when the involved physicians merely pass along their views to payers, do not agree to "fix" prices, and do not boycott or threaten to boycott recalcitrant payers. Yet, the statement as presently constructed not only eschews a safety zone for the collective provision of fee-related information to purchasers, but also bluntly warns that such conduct may ignite antitrust concerns.

The strident mentality revealed by the agencies in this respect is particularly perplexing since another statement creates an antitrust safety zone extending an umbrella of protection over the exchange of price and cost data by hospitals. The agencies, according to the statement, will not challenge, absent extraordinary circumstances, hospital participation in written surveys of prices for hospital services or wages, salaries, or benefits of hospital personnel, provided certain conditions are met.

The disparate treatment sanctioning hospital participation in exchanges of price and cost information yet abhorring physicians' collective provision of fee-related data to purchasers has no obvious legal or economic logic. Physicians, akin to hospitals, have a legitimate need to appropriately adjust prices as market conditions evolve. Moreover, there are about 700,000 physicians in America and only about 5,000 non-federal hospitals. This suggests that, if anything, the risk of this kind of anticompetitive behavior by hospitals is greater than the risk of such behavior by physicians.

Thoughts for the future

Although prevailing political winds may change direction abruptly, current winds seem to portend substantial changes in our present health care system. The current Statements of Antitrust Enforcement Policy already raise many physicians' concern, and if a highly regulated health care system under the thumb of government eventually evolves, then they may well be rendered inappropriate and obsolete. ⬡

"Physicians, akin to hospitals, have a legitimate need to appropriately adjust prices as market conditions evolve."

† Kronick et al. The marketplace in healthcare reform. *N Engl J Med* 328(2):148-152, 1993.

THE ODDS ARE GETTING LONGER!

Vital momentum seems to be draining from the health system reform proposal introduced by Governor Robert P. Casey a year ago. The Casey plan was presented as a five-bill package in the Senate, but the House of Representatives only got one of the bills—the health care alliance proposal known as the Health Security Plan.

The keys to loss of momentum are seen as slowness of the Congress to act on national proposals—thus failing to send a clear signal on the type of plan to develop on the state level—and the replacement of Senator Hardy Williams (D-Philadelphia) as chairman of the Senate Public Health and Welfare Committee. Senator Williams is prime sponsor of the Casey bills, but the Senate is now under Republican control.

Casey supporters do possess, however, some lingering hope for success. The General Assembly is in session until the end of November, and if Congress does act this summer, a Pennsylvania bill could be moved through the state House and Senate quickly this fall.

There has also been discussion behind the scenes on individual bills in the package, including medical liability reform, insurance consumer reform, and self-referral restrictions. The Society has been an active participant in these discussions, and the individual bills could be considered in this session.

For more information, call the Society's Department of Legislative Affairs at (800) 228-7823 or (717) 558-7750.

The author, Larry L. Light, is the Society's director of legislative affairs.

PHYSICIANS VIE FOR LOCAL POLITICAL CLOUT

According to various media reports and AMA sources, a growing number of physicians are tossing their hats into the political ring this year. One national paper reported that at least 43 physicians are seeking House and Senate seats.

In Pennsylvania, three physicians ran unsuccessfully for party nominations during the May primaries:

- John F. Perry, MD, of Mill Hall, Clinton County, an orthopedic surgeon, ran for governor in the Republican primary.
- John Karlavage, MD, of Williamsport, Lycoming County, a general practitioner, was one of three Democrats challenging incumbent Congressman Joseph McDade.
- Joseph Rudolph, MD, of Library, Allegheny County, an allergist with a subspecialty in emergency medicine, was one of seven candidates running on the Democratic ticket for incumbent Republican Congressman Rick Santorum's seat. Santorum ran for the U.S. Senate seat held by Harris Wofford. Dr. Rudolph is a State Society member.

In related news, David Worthington, son of State Society member John J. Worthington, MD, of Willow Grove, Montgomery County, will run in the general election as an Independent for governor.

AMA BOARD APPROVES UNIVERSAL ACCESS APPROACH

The AMA Board of Trustees in April approved the association's major advocacy initiative, which presents one approach to achieve universal coverage for and access to health services.

The approach incorporates:

1) an employer mandate for firms with 100 or more employees;

2) an individual mandate with affordable sliding-scale subsidies for individuals in firms with less than 100 employees;

3) a health IRA as an additional mechanism to complement the employer/individual mandate; and

4) a phase-in mechanism established at the time reform legislation is enacted.

This advocacy initiative is based on long-standing AMA policy reflected in Health Access America, and the AMA's most recent proposal for action, "Providing Health Coverage for All Americans."

The initiative represents the framework of a desirable approach, but also recognizes that as the congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage for and access to a standard set of health care benefits for all Americans.

This report also highlights that the AMA believes universal coverage and access to health care services are *not* in conflict but must be pursued simultaneously under health system reform legislation.

RADIO ADS SUPPORT MALPRACTICE REFORMS

Radio advertising supporting federal malpractice reforms is being aired in several states by the Health Care Liability Alliance, of which the AMA is a member.

The ads are running in the congressional districts of key members of Congress who deal with liability reform. In Pennsylvania, the ad aired in the legislative district of Representative Marjorie Margolies-Mezvinsky (D-Montgomery).

The text of the ads follows a similar script to the "Harry and Louise" television ads of the Health Insurance Association of America. The liability alliance's characters, "Larry and Mary," converse as follows:

Larry: Hey Mary, a $2 million plus jury award in my malpractice case...My client gets less than half. I get about $750,000...

Mary: Shh, Larry, people in Washington might hear. That could wreck our gravy train. Remember, 28 states already limit malpractice fees for lawyers and have made the system fairer.

Larry: You're right, Mary, this is one boat we don't want Congress to rock. (ambulance siren...) Gotta go...

Narrator: There can be no health care reform without liability reform. Call your congressman today. Let's change the rules and make the liability system better.

Call the Health Care Liability Alliance at 1-800-REFORM-1 for information.

AMA KICKS COMMUNICATIONS PLAN IN HIGH GEAR

AMA President James S. Todd, MD, in mid-May outlined the association's latest communications program, designed to utilize the strength of the federation to deliver medicine's message in the national debate over health system reform. He told the federation that, "The intensive national campaign is to make sure that our message is heard clearly and unmistakably by the Congress, the administration, the media, and the public."

Major activities include:

• On May 12, the AMA published an advertisement in the *Washington Post* attacking major health insurers' opposition to antitrust reforms as a part of health system reform. The ad was headlined, "What are they afraid of?" The AMA is calling for enactment of the Hatch-Archer bill (Senate Bill 1658/House Rule 3486), which provides antitrust relief for physicians.

• At the same time, the AMA sent a letter to every member of Congress, again voicing support for Hatch-Archer and making basically the same points contained in the advertisement. Every state medical society and most major national specialty societies signed on to this strongly worded letter, which states that "The undersigned organizations want to clear away the insurance companies' smoke screen and refute scurrilous arguments" regarding the AMA's antitrust relief legislation.

• Also on May 12, AMA Vice Speaker Richard Corlin, MD, testified before the Senate Labor Committee on antitrust reform, also supporting the Hatch-Archer legislation.

• On May 13, the AMA conducted a conference call with all 50 state medical societies to provide further details on activities, and to solicit support to maximize the impact of the campaign.

• The AMA held a press conference in Washington, DC, on May 23 to announce the "Patient Protection Act"—legislation to assure patient choice of physician in any type of managed care setting. Another ad appeared in the *Washington Post* that day, calling for support of this legislation, headlined: "What you don't know CAN Hurt You—That's why Congress MUST pass the Patient Protection Act."

• During the week of May 16, the AMA sent a letter to every physician and medical student in the U.S., to involve physicians at the grassroots in a campaign to build congressional support for the Patient Protection Act. The letter offered physicians the opportunity to send messages to the representative from their district and both senators from their state by placing a single phone call. It also encouraged personal contact with representatives in Congress in support of the act.

• Grassroots campaigns were also launched among the AMA POWER Network, the AMA Alliance, and interested physicians. These are to be complemented by a patient grassroots campaign, with physician office distribution of a brochure with letters to Congress, an 800 number for patients to call, and formation of a PATIENT POWER network. One goal was to arrange a one-on-one meeting in every congressional district during the Memorial Day recess to discuss the Patient Protection Act.

According to the AMA, the results of recent surveys, showing that the public believes physicians are the most important source of information on health system reform, demonstrate beyond a doubt that medicine's efforts are achieving significant results.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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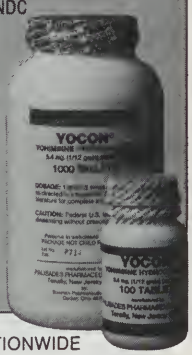

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How to Thrive in a Capitated Environment

The key to thriving—and not merely surviving—in a capitated environment is knowing key aspects of your practice's finances first-hand before accepting a managed care arrangement. Critical business decisions in today's managed care environment can no longer be based on a physician's intuition or a group's overall impression of what the practice can handle.

At the most basic level, knowing the financial ABCs of your practice includes calculating your costs on a per-member, per-procedure, and per-month basis. While obtaining these figures is not complex, it may require retooling your practice's information systems to access the information.

Organizing key financial data is the first step to obtaining actual knowledge of how your practice operates. Once armed with this baseline information, you can then determine whether a managed care plan's terms—from reimbursement fees to administrative details—are acceptable. Translating practice management information into comparable managed care terms will not only enable you to position your practice now, but for the future.

Revenue analysis: To determine whether a capitation arrangement will be profitable for your practice, you first need to evaluate your practice's current revenues. Compiling a productivity report, essentially a 12-month spreadsheet, will provide a summary showing each month's charges, adjustments to charges, collections, and capitation income for each payer and each payer contract.

Be sure to distinguish between payer and payer contract, since an arrangement from Blue Cross may include a traditional indemnity plan, a preferred provider organization (PPO), and a health maintenance organization (HMO). The spreadsheet should include the year-to-date totals, the previous year's comparison, and the accounts receivable aging.

This information provides an immediate comparison and quick analysis of which programs are providing adequate revenues and which should be reduced or possibly discontinued. Many practices participate with 15 or 16 plans—but actually receive income from only four or five. You might want to question what to do with those other nine or 10 plans that are clogging up your files and not providing you with much revenue.

Segment analysis: As part of your effort to organize practice management data, include a segment analysis that presents the different types of services and procedures provided by your practice and the volume of each in total and by payer. This report should list examinations, consultations, surgical cases, and post-operative visits, as well as a summary by diagnosis.

Developing a segment analysis will help you determine how a particular plan's enrollees compare to your current patient population. For example, if a high percentage of a plan's patients are diabetic, utilizations are likely to be higher and resulting profits will be lower. This information will be very helpful in determining whether or not you will be able to continue accepting patients from a particular payer and may give you the ability to negotiate a more appropriate rate with the managed care organization.

Patient demographic data: Similar to the segment analysis, a summary of demographic data, including age, sex, ethnic origins, zip codes, and household income, provides another baseline by which to compare the existing demographics of your patients to those of a new plan. This comparison will also serve as a good indication of potential utilization rates.

Referrals out: Include a report that summarizes the number and types of diagnoses "farmed out" to other physicians. This will give you an indication of how many referrals you are making and the type of specialty to which they are directed.

The Health Care Group

Calculating fees

Before you can begin to compete on prices, you need to know your practice's operating costs. To determine whether capitation rates or other forms of reimbursement are adequate, have a clear understanding of physician and staff salaries per procedure, as well as other overhead costs, including tests performed. While this may be initially time-consuming, once the system is in place, keeping track of costs is fairly easy.

The steps below show you one way to determine if a capitation contract is profitable. This method assumes a fairly tight correlation between the fees for a procedure, and the work and overhead included. If there is no such correlation, there are other, more exact methods available.

To calculate your average cost:

1) Compile your total expenses from the most recent fiscal year. These should include staff and physician salaries and bonuses.

2) Compile the total charges for services rendered during the most recent fiscal year. If you cannot obtain this information by date of service, compile all services billed in that fiscal year.

3) Compute this information into a "cost-to-charge" ratio, by dividing total practice expenses by total charges. This will tell you what percent of each dollar charged goes to covering practice costs.

4) For each procedure you perform, calculate the minimum charge as the usual and customary fee by the ratio of cost-to-charges. This will tell you the lowest amount you can accept for this service to still cover your costs.

Evaluating capitation agreements

Following a similar procedure will provide a clear way to evaluate the profitability of a proposed or existing capitation agreement:

1) Compile a list showing how many procedures you perform under a capitated plan.

2) For each procedure, multiply the number performed by the minimum charge.

3) Add up all the figures produced in step 2 for all procedures performed. This total is the minimum you would have charged for services performed if you billed them at an average cost.

4) Compare the total from step 3 with the total capitation payment received during the year. If the capitation is greater than the total average charges, you are profiting with the agreement. If the capitation is less than the total average charges, you are not covering your average costs. Further research may be needed by your accountant or adviser to determine if you should continue under such a capitated agreement.

Preparing for negotiations

Retooling your practice's information systems to institute accrual accounting systems, organizing claims analyses, or measuring outcomes are necessary prerequisites to any negotiations with managed care organizations. Accepting a reimbursement arrangement without knowing your own cost parameters only reduces your negotiating leverage and potential for profitability in a managed care environment.

The contributing author, Patrick M. Bernet, MS, MBA, is a consultant with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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Society Publications Address Personnel, Employment Issues

If physicians have questions about their role as an employer or an employee, they can turn to two publications from the Pennsylvania Medical Society. Both are written by respected health care attorneys, and are easy to read and use.

"Employment Contracts: A Guide for Pennsylvania Physicians" answers many of the legal, professional, and personal questions that arise when contemplating contracting from both the employer and employee perspectives. It is discount priced at $40 for Society members; the price is $60 for nonmember physicians and non-physicians.

"Employment Law: A Guide for Pennsylvania Physicians" is the best guide to government laws and regulations affecting physicians who are employers. The cost of the Employment Law manual is $45 for Society members, $75 for nonmember physicians, and $100 for non-physicians.

To order, or for more information about the manuals, call the Society's Department of Physician Services at (800) 228-7823 or (717) 558-7750.

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Personnel Considerations in a Practice Merger

Monica M. Murphy

Many doctors have begun discussions with their colleagues about the pros and cons of merging practices. Legal and financial aspects of a merger often overshadow the pragmatic considerations in personnel, but changes in personnel should be discussed, in detail, before a practice merger is finalized to eliminate any surprises or hard feelings.

To begin, the types of employees needed in the newly formed entity must be evaluated, as well as the strengths and weaknesses of current employees. Some groups appoint one or two doctors to perform this task, while others seek outside consultants. Either way, these guidelines can be used to assess personnel effectively.

Define job descriptions

First, define job descriptions for the new entity, and then the appropriate employee can be assigned to each job. During this process, however, you may discover that too many employees are qualified for the same job, or none are qualified for a particular job.

For example, the new entity may require two medical assistants and one nurse; yet, each practice currently employs two nurses. In this case, you have two choices: 1) retain one nurse and hire two new medical assistants, or 2) retain all currently employed nurses. While the added expense of the latter alternative may be worthwhile to maintain patient comfort level, there may be another problem to consider: Many nurses have been with their respective practices long term and are comfortable working with "their doctors" and doing things "their way."

And this is not only true for the clinical staff, but the clerical staff as well. That is why it is crucial for you to discuss personnel issues prior to finalizing an agreement to merge practices. If you commit to forming a new entity, you must also commit to making changes along the way.

Assign job responsibilities

Once the job descriptions have been defined, you can then decide to whom these responsibilities should be assigned. Invest the time and money needed to meet with each staff member to evaluate his or her strengths and weaknesses. Start by asking the employee to describe "a day in the life" at work. Take note of the duties the employee enjoys and those he or she avoids at all costs.

For instance, your office manager may spend more than 80 percent of his or her time following up on overdue patient accounts, and he or she may show no initiative in keeping informed about reimbursement changes or general changes in the health care environment. However, your newly established practice will need someone to be the liaison between you and "the outside world"—someone you depend on for information about your current managed care plans, other third-party payers, operational issues, staffing issues, and general practice management issues.

Since a billing coordinator, not an office manager, should follow up on overdue accounts, the employee who formerly served as your office manager may really be best-suited for a billing coordinator position. Or perhaps your office manager has the ability and desire to be more of an administrator; however, he or she was not given the opportunity to pursue this avenue. An outside adviser could train this employee, and recommend effective training materials and seminars.

Critique each job description and assign a corresponding staff member. You may have some difficult decisions to make at this point, and some compromises may have to be made—cost and efficiency versus staff history. This is not necessarily a negative and should not be viewed that way. If it is decided that all nurses will be retained, even though it would be more cost-effective to replace them with medical assistants, then clarify the reasons why and move on. Do not dwell on the added costs if the majority of doctors don't want to completely overhaul the practice.

Continuity of patient care provided by long-term employees can be helpful for the patients. The less obvious the practice changes are to the patients, the better the transition will flow.

Address employees' perceptions

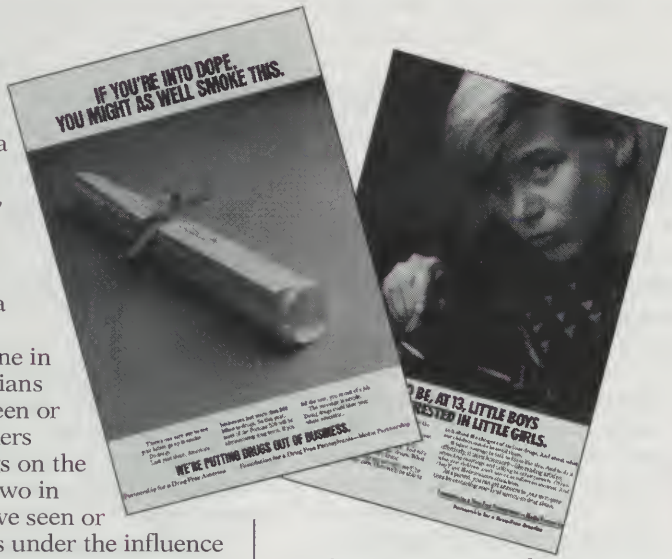
Finally, the employees must believe the changes are for the benefit and long-term stability of the practice. The decision to merge practices should not be viewed as a selfish move on the part of the doctors.

Include certain key personnel during some of the decision-making process. This is not to say that you should allow staff the authority to define new employee roles, but key employees could be given the opportunity to make suggestions. Make your staff members feel like they are a part of the practice, and the results will prove positive.

In summary, do not downplay the importance of personnel changes in the process of merging practices. Your staff is a critical piece to the pie and should be treated accordingly. They may have suggestions that might not cross your mind, yet be vitally important. Thoughtful planning for the legal, financial, and personnel issues will definitely pay off in the long run.

Ms. Murphy is a medical practice management consultant for Professional Practice Consulting, Inc., Wayne.

Anti-Drug Abuse Effort Targets the Workplace



Pennsylvania workers think drugs and alcohol are a problem in their own workplaces, according to a recent Gallup Survey for the Foundation for a Drug Free Pennsylvania. One in four Pennsylvanians surveyed have seen or heard of coworkers using illicit drugs on the job, and nearly two in four say they have seen or heard coworkers under the influence of alcohol while at work, the study found.

The study was presented at the launch of Drugs Don't Work Here (DDWH), a new statewide program from the foundation that will help employers and labor organizations address drug and alcohol abuse in the workplace.

The State Society is a founding member of the foundation, incorporated in 1990 by a coalition of business, labor, and professional organizations in response to a call from Governor Robert P. Casey and Attorney General Ernest Preate Jr., for the private sector to play a larger role in addressing the problem of substance abuse. Lee H. McCormick, MD, State Society hospital medical staff trustee, represents the Society on the foundation's Board of Directors.

Benefits of DDWH membership include discounts on advertising and selected goods and services from other DDWH members. A number of drug testing labs, employee assistance programs, medical review officers, and several medical organizations are offering various discounts to all members who use their services.

The foundation chose the workplace as its initial primary focus for several reasons:

- the need is great, and much needs to be done in this area;
- the vast majority of drug users can be reached through the workplace; and
- substance abuse in the workplace is taking a tremendous economic toll on the nation and the commonwealth.

The foundation's initial approach was to offer a series of seminars to help small and mid-sized employers address substance abuse in a comprehensive manner.

The series of seven seminars was attended by nearly 300 organizations with approximately 140,000 employees. More significantly, a high proportion of employers were motivated to institute, revise, or at least reexamine existing substance abuse policies, employee assistance programs, and/or drug testing programs.

The foundation is addressing one unique workplace separately: schools. The federal Drug Free Schools and Community Act requires any school receiving federal funds to certify that it is a drug-free workplace. The foundation, in conjunction with the Pennsylvania Department of Education, designed a seminar to help school districts understand and comply with the federal requirements.

A second major initiative of the foundation is a statewide anti-substance abuse public service media campaign called the "Foundation for a Drug Free Pennsylvania—Media Partnership." All television station, cable network, radio station, newspaper, and billboard companies across the state have been asked to become "partners" in promoting the foundation's message. The foundation estimates that, in the first nine months of the program, 82,996 ads valued at $1.8 million have been run.

The foundation is funded primarily through contributions from corporations and foundations, and has also received grants from state government.

PUBLIC HEALTH TOPICS POPULAR IN HEADLINES

Keeping up with news in the arena of public health is a difficult challenge for physicians nowadays who are bombarded with an ever-increasing barrage of "instant access" information. As a small help, here's a sample of headlines gleaned from various sources received by the State Society:

- The federal Agency for Health Care Policy and Research has formed a private-sector panel of health care experts and consumers to develop clinical practice guidelines to improve the effectiveness of smoking prevention and cessation programs.
- A federal judge ruled in May that the U.S. constitution guarantees people the right to terminate pregnancies and the right to end their own lives. A U.S. District Court in Seattle struck down a 140-year-old Washington state ban on assisted suicide, saying the law violated 14th Amendment guarantees against state infringement of individual liberty.
- The AMA will call for physicians to disclose their rates in advance to patients and to use the federal RBRVS fee scale as the basis for their fees.
- Wyeth-Ayerst Labs is offering safe-sex kits to providers containing a sample condom and discount coupons.
- The FDA is imposing stricter rules on food labels. The FDA and Department of Agriculture have added the word "healthy" to the list of terms they will regulate. No longer will foods low in fat—like jelly beans—be able to be labeled as healthy.

Emergency Medicine: Ahead of the Rest

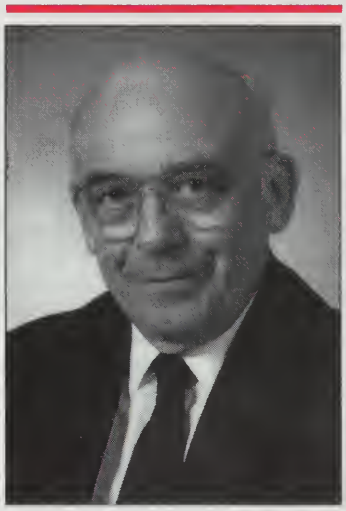
Maureen Hoepfer

George E. Moerkirk, MD, FACS, is director of prehospital emergency medical services and former medical director of aeromedical services at Lehigh Valley Hospital in Allentown. Since the early 1960s, Dr. Moerkirk has been a driving force in statewide efforts to develop and maintain a quality emergency medical services system in Pennsylvania.

George Moerkirk, MD, says that emergency care in Pennsylvania has come a long way since he began practice in the early 1950s. "Back then, we operated on the scoop-and-run principle of prehospital care. There were ambulance services, many of which were run by funeral directors who used their hearses as the transport vehicles for trauma victims. There were no training standards for prehospital providers, the equipment was crude, and really we only provided transportation for the patient. I've seen people put in the back of vans with only a driver taking them to the hospital."

Today, the situation is vastly improved, according to Dr. Moerkirk. Pennsylvania has developed a comprehensive emergency medical services (EMS) system that includes specially trained personnel in both the prehospital and hospital settings, licensed ambulances furnished with the latest technological equipment, a sophisticated communication system, and designated trauma centers.

"I think our greatest accomplishment has been setting up this system of care," he explains. "There is no question that the EMS system has had a significant impact on reducing mortality and morbidity statistics for trauma in Pennsylvania."



Dr. Moerkirk

A costly problem

Trauma is a large, costly problem in the United States. Dr. Moerkirk cites the following statistics published by the American College of Surgeons:

- Trauma is the leading cause of death for persons up to age 40, and the third leading cause of death for Americans overall.
- 45,000 Americans die from trauma each year, and 60 million are injured.
- The costs for treating trauma-related injuries in the U.S. exceed $100 billion each year; this comprises 40 percent of the nation's total annual health care expenditures.

"It's interesting that even though the United States spends billions of dollars on treating trauma victims each year, only four cents of every federal research dollar is spent on trauma research," he adds.

The EMS movement

The push to improve emergency care in the U.S. began in the early 1960s, Dr. Moerkirk says. The National Research Council and the American Academy of Sciences jointly published a paper, "Trauma: The Neglected Disease in Modern Society," which called attention to the deficiencies in emergency medical care. Soon after, Congress passed the Highway Safety Act which included funding to states for programs to train emergency medical technicians and paramedics.

"Around that same time," he says, "Congress also enacted an EMS act which allowed regions within states to organize and apply for grants to implement basic and advanced emergency medical services systems. Pennsylvania succeeded in obtaining a large number of these grants." He adds that a number of regional EMS councils de-

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

veloped in Pennsylvania as a result of this act, including the Eastern Pennsylvania Regional Council. Dr. Moerkirk helped to organize the council in 1972 and has served as its medical director since the beginning.

However, he believes state legislation—the Pennsylvania Emergency Medical Services Act (Act 45), enacted in 1985—had the biggest impact on improving emergency care in the state. "Act 45 was an omnibus bill which addressed all aspects of setting up a system of emergency care—it mandated that all ambulances in Pennsylvania be licensed, set standards for training emergency personnel, provided funding for the development of an emergency communication system, and established the Pennsylvania Trauma Systems Foundation, whose primary role is to accredit trauma centers in the state."

EMS pioneer

Since the 1960s, Dr. Moerkirk has played a major role in improving emergency care on the state level and in the Allentown area. For example, he says that when he became medical director at Sacred Heart Hospital in Allentown in 1966, the hospital's emergency department was staffed primarily by first-year interns. To correct this deficiency, he organized a group of physicians who incorporated and contracted with the hospital to cover the emergency department full-time. This eventually led to the hospital hiring emergency physicians for the emergency department.

On the state level, Dr. Moerkirk helped set up the Pennsylvania Trauma Systems Foundation (PTSF) and the Pennsylvania Emergency Health Services Council (PEHSC), a statewide organization which advises the Pennsylvania Department of Health and the regional EMS councils . He served as PEHSC president from 1980 to 1983 and again from 1990 to 1993. He is also currently on the board of directors of both PTSF and PEHSC.

Dr. Moerkirk says he is most proud of the part he played in establishing the Emergency Medicine Institute (EMI) in 1987. The institute, part of the Lehigh Valley Hospital, trains all levels of health professionals—first responders, emergency medical technicians (EMTs), paramedics, nurses, and physicians—in the management of trauma and urgently ill patients. To this day, Dr. Moerkirk is personally involved in training EMTs and paramedics. He estimates that he has trained more than 500 paramedics and 2,000 EMTs.

Decline of EMS volunteers

Since the beginning, the EMS system in Pennsylvania has depended on volunteers, but this is beginning to change, according to Dr. Moerkirk. "The voluntary system in Pennsylvania has declined, and it's become a predominantly paid system which significantly increases the cost. As with all areas of health care, EMS is going to be significantly affected by health care reform."

He explains, "Hospitals have already begun to find ways to cut costs in the emergency departments, and ambulance corps are going to have to do the same thing. I think the ambulance corps that are going to be able to provide care at a reasonable cost are those that have been successful in blending volunteer and paid staff in the same corps."

Pennsylvania's EMS system would particularly benefit from more physician volunteers, Dr. Moerkirk says. He encourages physicians to become medical directors for ambulance corps, and instructors for EMT, paramedic, and CPR courses, and to volunteer for medical command positions.

He says he has found his experience in the EMS system to be "extremely rewarding," especially his role in training EMTs and paramedics. "I get incredible satisfaction from watching the different people I train grow. I always try to encourage them to advance their knowledge and growth in the system, and the vast majority of them do."

He adds, "I recently had a man come to my office who I had treated years before for severe arm injuries. He came to thank me and tell me that he was certified in CPR and was in training to become a first responder. I can't describe the feeling you get when you've helped someone, and he or she comes back and wants to put something back into the system. It makes everything worthwhile." ⬡

The Development of Emergency Medicine

Following the battlefield experiences of the Korean and Vietnam wars, physicians began to recognize that prompt, effective action in the first minutes of an emergency could save thousands of Americans each year. The need for specialized training to provide quality emergency care motivated a group of eight physicians in 1968 to form a professional association for physicians practicing in emergency departments. The American College of Emergency Physicians (ACEP), with a current membership of more than 17,000, was instrumental in establishing emergency medicine as a specialty.

In September 1979, ACEP's efforts met with success when the American Board of Medical Specialties voted to approve emergency medicine as the 23rd medical specialty. Today, there are more than 11,000 board-certified emergency physicians in the United States.

For more information on emergency medicine or on how you can become more involved with emergency medical services in your area, call the Pennsylvania Chapter of ACEP at (800) 228-7823, extension 463.

Spring Assembly '94

Physicians Prepare for System Changes

Maria T. Montesano
Assistant Managing Editor

It's easy to liken the U.S. health system reform debate to a game of chess: Clinton's presidential campaign was the challenge, followed by months of exchanging moves after his inauguration. But now we seem caught in the middle—each move, carefully designed; the outcome, difficult to call. And all the while, physicians' futures rest on that outcome.

In an effort to prepare physicians for the changes to come and the roles they may be asked to play, the Society focused its annual Spring Assembly on "Forging Alliances...Assuring Your Future." Speakers discussed the future of health system reform, and workshops offered tools to help physicians deal with the future.

More than 275 members attended the meeting, held April 19-20 in Harrisburg.

At issue: reform financing

Richard F. Corlin, MD, vice speaker of the AMA House of Delegates and a graduate of Hahnemann University School of Medicine, has seen the uncertainty of health system reform before. As a recent past president of the California Medical Association, he has dealt with changes in that state and their impact on physicians.

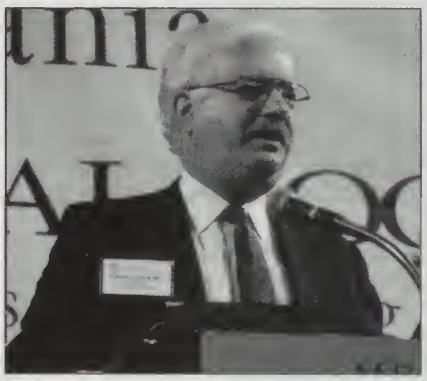
Dr. Corlin relayed his knowledge and experiences in the assembly's keynote address, which focused on: "What is our perception of what we think is going on, and what can we expect out of Washington?"

At issue is the financing of health care in the U.S., according to Dr. Corlin, and he outlined what he sees as our only two choices: 1) continue the employer mandate, or 2) use a tax base. "If you take a look at what we have learned from the combination of experience and elections, and the results of polling," he explained, "by a process of elimination, we are left with one potential tax source to fund health care...a payroll tax—the majority paid by the employer, a small portion paid by the employee."

He said, "In the final analysis there are two sources of money: the employer mandate or a payroll tax. In either case, the business community will be paying for health care."

He then overviewed the principles behind the AMA's Health Access America reform plan—commitment to universal coverage, employer mandate, tort reform, and antitrust relief—the same principles behind President Clinton's approach to reform. "Any of us who watched President Clinton's September 22 speech had to come away with a conclusion that that was a masterful speech, and there was virtually nothing in that speech that anybody could've disagreed with," he said. "The question we raise is, How did we go from that speech to the plan that a lot of us have so very much trouble with?"

Dr. Corlin believes President Clinton "clearly and unequivocally campaigned on and delivered on the commitment to put a health care delivery system before the American people, and he did. The *way* he did it," he added, "is the seed of many of the mistakes and many of the problems that have occurred."



Richard F. Corlin, MD, vice speaker of the AMA House of Delegates and recent past president of the California Medical Association, discussed in the assembly's keynote address his experiences with health system reform.

He said one of the president's mistakes was the manner in which the developmental panels were put together—the administration violated "Millers' Laws," a concept Dr. Corlin learned in England. Miller's Laws say:

1) Physicians with real experience treating patients, and administrators with real experience administrating, must be involved in the development of any government program affecting the health system.

2) All planning of the program must be done on a local level.

3) Don't allow the program to become a partisan political football.

He believes that, in the end, any plan that follows Miller's Laws is a "good" plan, and any plan that does not is a "bad" plan.

Of the president's plan, Dr. Corlin doesn't think we'll see alliances as proposed, but he is anticipating that

The Law of the Jungle

This is the law of the jungle, it's as old and as true as the sky.

And the wolf that shall keep it may prosper, but the wolf that shall break it must die.

Like the creeper that girdles the tree trunk, the law runneth forward and back.

For the strength of the pack is the wolf, and the strength of the wolf is the pack.

—from Rudyard Kipling's The Jungle Book, *quoted by Richard F. Corlin, MD, at the Society's 1994 Spring Assembly, in his keynote address which stressed the need for physician unity nationwide.*

Kenneth E. Thorpe, PhD, deputy assistant secretary for health policy, U.S. Department of Health and Human Services, brought the White House's view of the future of health system reform to the assembly.

"something will pass" to ensure universal coverage, and it will include some insurance underwriting reform and some tort reform. However, he said, "it probably will not have the antitrust relief that we want" and will not adequately address cost containment.

The AMA is committed to a health system reform proposal that "abides by Miller's Laws, is honestly financed, and has the ability to deliver 100 percent of what it promises," Dr. Corlin said.

In conclusion, he offered this message for all physicians: "What's under discussion now are just two things: How will you be able to treat your patients, and how—and how much—will you be paid for doing it? If those two things are enough to gather your attention, then you should pay attention to what's going on...We didn't get where we are by not being informed...We have got to remain united in our response, and how good the outcome is for us is directly proportional to that unity."

The future of reform

Kenneth E. Thorpe, PhD, deputy assistant secretary for health policy, U.S. Department of Health and Human Services, and a native of Indiana, Pennsylvania, brought the White House's view of the future of health system reform to the assembly.

After reviewing the five major themes of President Clinton's reform plan—guarantee universal coverage, allow individual choice of physicians and health plans, outlaw unfair insurance practices, preserve Medicare, and guarantee health benefits at work—Dr. Thorpe discussed the problems he sees physicians and patients facing under the current health delivery system.

First, he cited that, given the way the system is set up, power is increasingly residing in the hands of health insurers. "If you look at the last 10 to 15 years, there's no question that physician autonomy, and how you practice medicine, have changed quite substantially," he said. "Some of this has to do with the fact that employers are entering into exclusive contracts with insurance companies that have tremendous leverage over providers, [and] physicians have increasingly less negotiating leverage...Insurers can drop them without process." With respect to patients, he said, they often don't know what benefits they're getting until it's too late.

> ***"In the final analysis there are two sources of money: the employer mandate or a payroll tax. In either case, the business community will be paying for health care."***
>
> *—Richard F. Corlin, MD*

Second, he cited the problems of paperwork and bureaucracy. "We've seen that paperwork and the bureaucracy often overwhelm providers," Dr. Thorpe said. "The cost of billing and the overhead costs of running a physician's office continue to increase over time. A lot of it has to do with the proliferation of competing plans offering variations on benefits, as well as very different forms and different amounts of coverage." The administration is proposing to "fix" this problem through form standardization and uniform benefits.

He also said that the plan addresses access problems and distribution of physicians, and he hopes it allows freedom of choice for physicians and individuals, changes in the balance of power, and antitrust relief—three issues which he said are gaining increasing support in Washington.

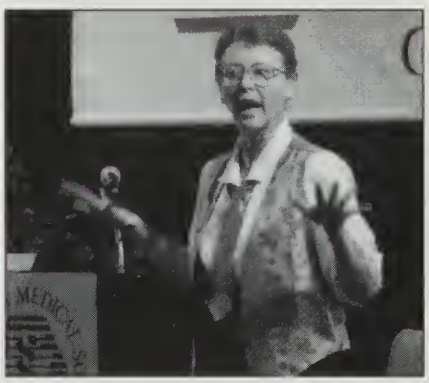
Dr. Thorpe encouraged attendees to be active participants in the health system reform debate. "As long as we've been discussing this issue, many people still remain somewhat ill-informed; information and feedback from providers is essential." He concluded that no health system reform proposal would go through "without the active support of the provider community."

Dealing with the future

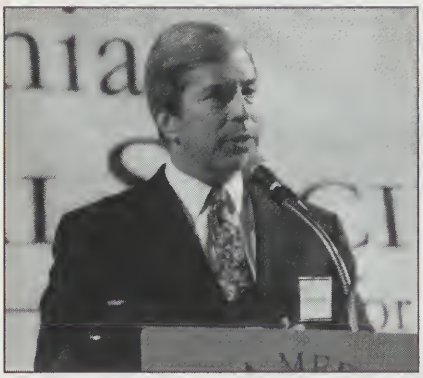
Jennifer James, PhD, received "excellent" marks from assembly participants for her heartfelt, yet witty presentation on dealing with change and the future. As a cultural anthropologist, she said her job is to study change and how people adapt to it—a necessity for survival.

Speaking about health system reform, she said she sees "tremendous resistance [by physicians] to accept reality." That resistance is understandable, she said: "You've worked hard, [and] now your integrity is being questioned." But such resistance is also a natural part of the acceptance process, which parallels the grieving process—including denial, anger, bargaining, and fundamental acceptance.

While she believes "professions should be able to reorganize themselves," Dr. James said society won't let them. Thus, to rebuild, physicians must get to the acceptance phase. But that's tough, she added: "No generation before has been asked to change as rapidly and as deeply as this generation is being asked to [change]. Mental health used to be [indicated by] stability; Now, it's indicated by the ability to handle diversity."



Cultural anthropologist Jennifer James, PhD, received "excellent" marks for her heartfelt presentation on dealing with change and the future.



Back by popular demand, Thomas M. Reardon, Esq., of Boston, discussed the concept and benefits of physician-controlled alliances and physician-controlled capitation which, he said, "works."

She likened medicine as we know it to a "lodge" or fraternal organization, and said to adapt to the medicine of the future, physicians must change medicine "from a lodge to a profession"—they must "open it up." She explained that by challenging the rituals and supply and demand, many things will follow:

- The hierarchy will change.
- Accountability will improve.
- Patients will become more informed.
- Ethics issues will be better addressed.

In closing, Dr. James offered the following advice for physicians in dealing with the changing face of medicine: Look at the problems; offer your insight; intervene where you can; try to handle your anxiety; watch out for nostalgia; imagine other possibilities; and foremost, "Don't let the grief process stop you."

Forging alliances

One of last year's most popular presenters, Thomas M. Reardon, Esq., of Boston, specialist in health law and chairman of the board of the Massachusetts Eye and Ear Infirmary, returned to Spring Assembly this year to talk about physicians developing relationships with hospitals, financing entities, and other physician groups.

"Today, I'd like you to open your minds and think of things in a little different way," Reardon began, "because I think in the health care field, the world is going to be turned upside down. What was bad will become good, and what was good will become bad," he said, "and let's not kid anybody: Somebody's going to get hurt."

What health system reform is really about, he said, is not what will come out of Washington—that will be "largely irrelevant." Instead, the question is, "Who's going to control the system?"

"No generation before has been asked to change as rapidly and as deeply as this generation is being asked to [change]."

—Jennifer James, PhD

". . . I think in the health care field, the world is going to be turned upside down. What was bad will become good, and what was good will become bad . . . and let's not kid anybody: Somebody's going to get hurt."

—Thomas M. Reardon, Esq.

Six groups are battling for control, according to Reardon: insurance, health maintenance organizations, government, business coalitions, hospitals, and physicians. Currently, the West Coast is controlled by managed care players, the Midwest is controlled by business coalitions, and the East Coast is regulated by the government, he explained, noting that in all areas, "somebody else has been driving the system." But he sees physicians' roles expanding in the future—through physician-controlled alliances, whether they be physician-hospital organizations or group practices.

Reardon is an advocate of physician-controlled capitation. He explains the concept: "You hand a dollar to a primary care physician, and you say to that primary care physician, 'Keep this dollar away from the specialists, and keep it away from the hospital—and, by the way, you'd better assure quality of care—and if you do all that, you can put the balance in your pocket.' " He said, "Human nature is such that it works."

He left the audience with the following three suggestions to assure physicians a position at the game board in the future: 1) aggregate physician power; 2) *really* learn about capitation; and 3) truly network and pick your partners.

Pennsylvania Medical Society President Martin A. Murcek, MD, opened the Wednesday morning session of Spring Assembly with a few thoughts on organized medicine and health system reform. *For excerpts, see page 8.*

WORKSHOPS OFFER TOOLS FOR THE FUTURE

Keeping with the themes of building alliances and assuring the future, the Spring Assembly offered attendees "tools for building alliances" through six concurrent workshops on Wednesday, April 20. Sessions focused on computers, medical staff networks, financial planning, communication skills, medical ethics, and managed care contracts.

Computers

Society Trustee Edward H. Dench Jr., MD, led "Computers Made Easy," a discussion of the basics of personal computers and their growing role in the health care system.

A personal computer user and adviser, Dr. Dench began with an overview of hardware components, before moving into a brief discussion of software available for use in physician offices and other technical considerations. He stressed that it is important for physicians to know what they want to accomplish with a system before they

Dr. Dench

purchase computer hardware and software.

Participants also received a detailed list of computer terms and definitions. The workshop ended with an extensive question-and-answer session.

Medical staff networks

Stephen M. Griffin, senior manager for KPMG Peat Marwick Management Consultants, presented "PHO...Friend or Foe?," a nuts-and-bolts workshop focusing on the considerations and ramifications of establishing medical staff networks—specifically physician-hospital organizations (PHOs) compared to physician organizations (POs).

A specialist in health care financial and strategic management, Griffin discussed horizontal versus vertical integration and the goals of physician integration. Questions posed by participants addressed time and financial considerations, physicians' roles in PHOs, governance and structure of PHOs, and economic credentialing.

Financial planning

Developed at the request of the Society's Young Physician Section, "Financial Planning in the Changing Environment" offered participants advice on planning for future financial security.

Led by Ronald J. Paprocki, JD, CFP, corporate vice president, AMA Investment Advisers, Inc., Chicago, discussion focused on various investment and insurance options, and how to be successful using them. He also overviewed basic investment terms, talked about the impact of taxes and investment alternatives, and offered what to look for in an investment adviser.

In guiding participants, Paprocki stressed the importance of planning—especially with the changing economic environment—and noted that each individual requires a different investment profile reflective of his or her own situation and long-term financial goals.

Communication skills

Robert Lamb, of The Institute for Physician Leadership of the Society's Educational and Scientific Trust, and Amy Dugan, the Society's director of media relations, led "Winning Approaches to Your Legislator and the Public," designed to increase physicians' grassroots lobbying effectiveness and public speaking by improving their communications skills.

During the first half of the workshop, Lamb outlined ideas and essential skills needed to communicate effectively with legislators. Attendees then participated in role-playing exercises to practice and evaluate their lobbying skills.

Dugan then "reminded" participants of skills necessary to speak effectively to the public—skills they already knew, "but may have forgotten," she said. She discussed confidence and credibility, as well as the different components of a good speech.

Medical ethics

In "Difficult Decisions for Patients and Their Families," Stuart Younger, MD, associate professor of medicine, psychiatry, and biomedical ethics, Case Western Reserve University, and

Dr. Younger

Ms. Gosfield

director of the Clinical Ethics Program at University Hospitals of Cleveland, talked about how to talk to patients and their families about medically futile care and other ethical considerations raised by health system reform.

He began by discussing the varying definitions of medical futility. Then, realizing the controversy and moral issues raised by medical futility, Dr. Younger overviewed options available to handle such cases and stressed the importance of hospital ethics committees.

He spent the last half of the program working through specific situations and publicized cases with his audience.

Managed care contracts

Alice G. Gosfield, a Philadelphia attorney specializing in health law and health care regulation, returned to Spring Assembly for her third appearance in four years to talk to participants about "Contracting with Managed Care Organizations."

Her presentation included an overview of what physicians should ask for when entering into contractual arrangements and a detailed analysis of related legal issues, such as understanding the context, credentialing and corrective actions, and utilization management. She also explained contract terms and issues, and how to evaluate a managed care plan.

Participants received several handouts, including two related articles written by Gosfield.

HMSS HOLDS TWENTIETH ASSEMBLY

The Society's Hospital Medical Staff Section (HMSS) Twentieth Assembly Meeting, held in conjunction with Spring Assembly in April, was attended by 119 physicians and guests.

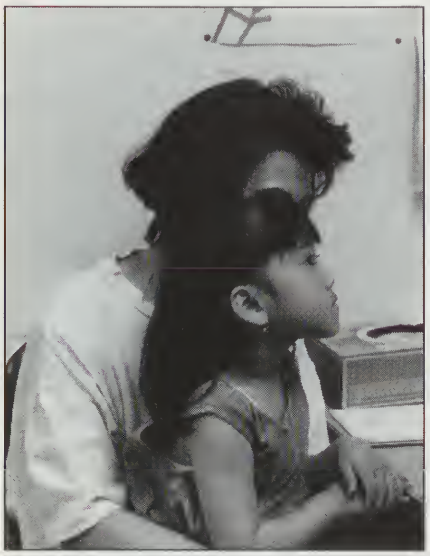
The educational program, "Forming PHOs: Hospital and Physician Perspectives," was well received. Speakers included Donald R. Creamer, president and chief executive officer of the Williamsport Hospital and Medical Center, and Bruce G. Silver, MD, section chief of geriatrics at Lankenau Hospital, Wynnewood.

Discussed during the open forum portion of the meeting were:

- the merger of Independence Blue Cross and Graduate Health Systems,
- representation on boards of physician-hospital organizations and other health care organizations, and
- HMO tactics for obtaining enrollees.

An audio cassette of the educational program is available for $8 by calling the HMSS at (800) 228-7823.

The Society's Hospital Medical Staff Section (HMSS) convened in April to discuss physician-hospital organizations and other current medical staff issues. Pictured above: HMSS representatives consider debate during the open forum portion of the meeting.



Four-year-old Felicia Nguyen, Harrisburg, sits on her mother, Hue's, lap while learning how immunizations will keep her healthy. Felicia received her pre-kindergarten immunizations during Pennsylvania Infant Immunization Week, April 23-29, 1994.

STATE OFFICIALS LAUNCH IMMUNIZATION WEEK

First Lady Ellen Casey and State Health Secretary Allan S. Noonan on April 25 launched Pennsylvania Infant Immunization Week in a ceremony at the Dauphin County State Health Center in Harrisburg. The effort was held in conjunction with Rotary International's project, "Operation Immunize Pennsylvania Kids."

Mrs. Casey, reading from a proclamation issued by Governor Robert P. Casey, said, "Vaccine-preventable diseases can cause serious health problems for children and can even cause death. Preventing diseases by immunization also prevents costly curative or long-term medical procedures that tend to raise the overall cost of medical care dramatically."

Dr. Noonan said statistics show that only 66 percent of Pennsylvania's children between ages 1 and 6 are adequately immunized. He also praised Pennsylvania's Rotary Clubs for their efforts: "Rotary has made this work through its promotion, volunteer activities, printing and distributing literature, and community outreach."

Mrs. Casey

Dr. Noonan

Roger F. Mecum, State Society executive vice president, also spoke on behalf of the Society, and following the speeches, preschoolers who had not received immunizations in the past received free ones from the health center nursing staff.

Pittsburgh Physician Recognized for Volunteer Efforts

The Pennsylvania Medical Society this year awarded its first-ever Physician Volunteer Award to Helen W. Gurson, MD, a family practitioner from Pittsburgh's South Side. The award, presented at the Society's Spring Assembly in April, honors Dr. Gurson's lifetime of unselfish devotion to her patients and community.

Helen W. Gurson, MD

One of three women graduates of the University of Pittsburgh School of Medicine, Class of 1942, she is well-known for her charity work—caring for all regardless of their ability to pay—and the diabetes control program she runs.

Soft-spoken and quite modest, Dr. Gurson explains the program: "I'm on the South Side of Pittsburgh, where we have the steel mills. A lot of the steel workers [afflicted with diabetes] must be at work at 6:00 in the morning. So, we opened our doors at 4:30 a.m., so we could take their blood, they'd have time to eat breakfast, and they'd still be to work on time."

She says her father was a severe diabetic, and she started the program to make it easier for people with diabetes to monitor their condition. "A lot of the patients didn't understand the disease and didn't take care of themselves—they didn't watch their diet, they didn't take their medication. This way, we'd make them aware of it." Check-ups are once every four months. Dr. Gurson says she currently has about 400 diabetic patients.

In 1992, Dr. Gurson received the Allegheny County Medical Society's (ACMS's) Nathaniel Bedford Award, which honors a primary care physician who has demonstrated long-term dedication to patients' physical and psychological needs. She has been a member of ACMS since 1945 and currently serves on its board of directors as chair of the South Hills Branch.

When asked what has given her the greatest satisfaction from being a doctor, she quickly, yet simply, responds: "Being able to help others." As for receiving the Society's Physician Volunteer Award, she says, It's an honor...especially from the State Society. In your own little corner, people know you, but from the State Society...this is wonderful."

TEENAGERS TO CONVENE AT ASSEMBLY THIS MONTH

About 500 teenagers from across the state are expected to convene in workshops, with topics ranging from business skills to non-violence, during the Second Annual Pennsylvania Martin Luther King Jr. Youth Assembly, cosponsored by the State Society. The three-day conference—the only state-level meeting of this type in the country—will be held June 17-19 at Millersville University.

Goals of the conference are to:

- familiarize youth with the philosophy and principles of non-violence as taught and lived by Dr. Martin Luther King Jr.;
- help youth understand and appreciate multi-cultural, multi-lingual, and multi-racial diversity and the importance of respect for others;
- teach youth the conflict-resolution skills they need to make responsible decisions to treat others with respect and love and as brothers and sisters;
- provide role models so that participating youth can develop self-esteem and moral concepts, so they value themselves; and
- convey the knowledge, skills, language, and habits that participating youth will need to function successfully in society and have a broad understanding of the world.

Dan Haro, coproducer of the film "Lives in Hazard," a story about youth violence, and an actor in "America Me," about Latino gangs and growing up in an urban neighborhood, and Willie Jolley, a prize-winning inspirational and motivational trainer, will also speak to the participants.

Workshop topics include:

- Ghandi's Call—a global perspective of non-violence and a look at the man who is called the father of India;
- King's Walk—a closer look at the civil rights movement and a discussion of its relevancy today;
- Law Enforcement, Friend or Foe—a presentation and open discussion regarding suspicious behavior and other miscommunication between youth and law enforcement officers; and
- Pop It, Smoke It, Inhale It, Stick It, Forget It—a look at today's drug culture, and how to avoid drug usage and drug wars.

Also included are: a presentation on what is happening with gangs in the state, and tips on how to avoid becoming a gang member and how to get out once involved; a frank discussion on the realities of prison, with Huntingdon State Prison inmates; tips on owning and operating a viable business; and identification of scholarships, financial assistance, and other information needed to help teens prepare for college.

One special segment of the conference involves participation in service projects around the Millersville area.

COUNTY NEWS

Bruce G. Silver, MD (at left), a Narberth internist and geriatric specialist, was inaugurated as the 134th president of the Delaware County Medical Society (DCMS) at the group's annual dinner meeting in March. A graduate of Jefferson Medical College, Dr. Silver is a member of the medical staff at Lankenau Hospital, Wynnewood, and medical director of Saunders House, a long-term care facility associated with the hospital. Also at the dinner, Senator Clarence Bell (R-Delaware) was honored for his record of service in the Pennsylvania Senate.

STATE SOCIETY REPORT

QUARTERLY REPORT OF HOUSE AVAILABLE

In accordance with Resolution 92-27 of the House of Delegates, the quarterly report on actions of the House is now available from the State Society. The report is provided to members to enable them to respond to and participate in upcoming House activities. To request a copy, call:

(800) 228-7823
extension 403

QUARTERLY REPORTS FROM KEPRO OVERSEERS

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. The chart below of recently profiled data covers the period April 1 through December 31, 1993.

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KePRO Fourth Scope of Work Retrospective Reviews

04/01/93 - 12/31/93

Inpatient Cases Reviewed: 20,975

	Number of Adverse Decisions	Number of Reviews	Rate
Admission Denials	320	20,855	1.53%
DRG Changes	260	19,268	1.34%
Confirmed Quality Problems	117	20,975	0.55%
Invasive Procedure Denials	2	7,915	0.02%
Day Outlier Denials	7	159	4.40%
Cost Outlier Denials	2	61	3.27%
Days of Stay Denials (Non-PPS Facilities)	0	1,616	0.00%

Ambulatory Surgery Cases Reviewed: 3,801

	Number of Adverse Decisions	Number of Reviews	Rate
Confirmed Quality Problems	186	7.484	2.48%
HCPCS/CPT Pay Group Changes	592	7,501	7.89%
Procedure Denials	1	7,501	0.01%

St. Francis Medical Center, Pittsburgh, has named **Lee H. McCormick, MD,** associate medical director of the outpatient network for the center for chemical dependency treatment.

W. William Shay, DO, Boyertown, was reelected president of the Acupuncture Society of Pennsylvania.

Todd Richard Fisher, MD, Middletown, a family practitioner, was elected as the 130th president of the Dauphin County Medical Society. Dr. Fisher is affiliated with the Family Medicine Center, Middletown. He succeeds **Virginia Hall, MD**.

James S. Studdiford III, MD, was appointed assistant professor of the Department of Family Medicine, Jefferson Medical College of Thomas Jefferson University, Philadelphia.

Dr. Cohen

Sidney Cohen, MD, the Richard Laylord Evans Professor of Medicine and chairman, Department of Medicine, Temple University Health Sciences Center, Philadelphia, has been named assistant vice president for the Health Sciences Center.

The American Brain Tumor Association has awarded to **Anna Julia Janss, MD, PhD,** neuro-oncology fellow, Division of Oncology, Children's Hospital of Philadelphia, a fellowship for 1994-96.

Lawrence A. Caliguiri, MD, Pittsburgh, was elected chair of the American Association of Allergy and Immunology's board of governors of national, state, and local societies.

Dr. Novak

Jospeh F. Novak, MD, Pittsburgh, received the Pennsylvania Academy of Ophthalmology's Humanitarian Service Award for his pioneering, life-long effort to promote eye safety in the steel mills of Western Pennsylvania.

St. Francis Medical Center, Pittsburgh, has appointed **Elmer J. Holzinger, MD,** senior vice president of academic affairs and development.

Fairman L. Denlinger, DO, was presented with the O.J. Snyder Memorial Award by the Philadelphia College of Osteopathic Medicine. This award recognizes an alumnus or alumna who has made significant contributions and has exhibited outstanding loyalty, leadership, and service to both the college and the osteopathic medical profession.

University of Pittsburgh Medical Center has named **William C. Lauerman, MD,** codirector of the newly formed comprehensive spine center.

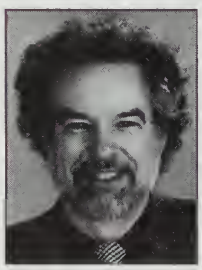
Ivo P. Janecka, MD, director, University of Pittsburgh Medical Center's Center for Cranial Base Surgery, received the American Academy of Otolaryngology's 1993 Head and Neck Surgery Honor Award.

Richard L. Simmons, MD, chair, surgery department, University of Pittsburgh School of Medicine, has received the National Kidney Foundation of Western Pennsylvania's Gift of Life Award.

Three Pittsburgh physicians, **Kenneth M. Irvis, MD**; **Oswald J. Nickens, MD**; and **Robert L. Thompson, MD,** were saluted in honor of Black History Month by the Healthy Start program for excellence in medicine.

Rodrigue Mortel, MD, professor and chair, Department of Obstetrics and Gynecology, Penn State's Milton S. Hershey Medical Center, Hershey, was elected president of the Society of Gynecologic Oncologists.

The Commonwealth Board Award of the Medical College of Pennsylvania, Philadelphia, has made a yearly mission of honoring graduates who are the best doctors and medical researchers in the state. This year's recipient is **Mary Ann E. Keenan, MD,** chairperson of orthopedic surgery, Albert Einstein Medical Center, Philadelphia. Dr. Keenan was the first, and currently is the only, woman to chair an orthopedic surgery department and residency training program in the United States.


Dr. Pertschuk

Michael J. Pertschuk, MD, Villanova, will serve as medical director of a new eating disorders center being developed at the Friends Hospital, Philadelphia.

Mark H. Blecher, MD, associate surgeon, Wills Eye Hospital, Philadelphia, was elected president of the Pennsylvania Academy of Ophthalmology.

Haig H. Kazazian Jr., MD, was appointed chairman, Department of Genetics, University of Pennsylvania Medical Center, Philadelphia.

Donald H. Silberberg, MD, chairman, Department of Neurology, University of Pennsylvania Medical Center, Philadelphia, was selected co-editor of *Multiple Sclerosis*, a new international peer-reviewed journal.

Sze-ya Yeh, MD, chairman, Department of Obstetrics and Gynecology, Albert Einstein Medical Center, Philadelphia, was awarded the Society of Perinatal Obstetricians' Achievement Award.

Four Pennsylvania Medical Society members—**James L. Cristol, MD;** Philadelphia County; **Daniel B. Kimball Jr., MD,** Berks County; **John R. Martell Jr., MD,** Allegheny County; and **Carl A. Sirio, MD,** Allegheny County—have been named to the AMA's Federation Study Consortium. Created at the direction of the AMA House of Delegates, the consortium is charged with: analyzing the functions, processes, and structural relationships among physician organizations, and recommending improvements. The AMA says the goals of the consortium are: "to create an environment in which all of medicine can better speak with one voice about issues affecting patients, and to develop mechanisms through which organized medicine can function more efficiently and effectively."

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Quality Care Is Reform Priority

Donald E. Harrop, MD

How health system reform will finally "shake out" in Pennsylvania remains a mystery to us all. This month, we consider that mystery and reform's most important provision—quality care.

Since KePRO has a vested interest in the future direction of health system reform at both the national and state levels, I've been trying to keep up with the various reform proposals being sponsored by our legislators in Washington and in Harrisburg. This is no easy task since there are so many proposals being introduced and so many opinions on what kind of benefit package should be mandated and how the program should be financed.

There seem to be quite a few legislators from both sides of the aisle who do not support the Clinton Administration's plan, some because they think it creates a huge new bureaucracy, some because the reduction in choice of physician under the managed care concept may not be popular with their constituents, some disbelieve the numbers used as the basis for financing it, and some for a wide variety of other reasons.

Although all indications point to eventual passage of some type of reform, I feel quite certain that it will take a lot longer than expected for passage of a national program. In fact, history tells us that back around 1970 through 1974, national health insurance looked like a sure thing. Many senators and congressmen were involved with proposing some sort of program. Then it all went quietly away, because no one could figure out how to finance it.

I'm not saying that the same thing will happen this time since I think there is more public support and more momentum now. However, whatever kind of program finally passes may not resemble what we have recently seen proposed.

Meanwhile, the Clinton Administration is promoting the idea that states should take some initiative and institute their own reform programs. The states that do would probably act as test sites for reform plans similar to the national proposal. In Pennsylvania, I will be curious to see what kind of support there is for the Casey Administration's reform package.

Except for the on-again, off-again Democratic/Republican majority in the Senate, this state could possibly have become a test site for reform since the Casey plan very closely resembles the Clinton proposal. In fact, at this point in time, many would argue which plan came first. Had the Democrats maintained control in the Senate from the start, the Casey plan may have had a chance for passage. However, because the governor's term will expire in about six months, his chances of getting a plan passed before he goes out of office are growing dim.

The new governor, whether Democrat or Republican, will most likely offer some difference in approach to health system reform. The amount of difference and the efforts made to accomplish passage will depend upon who becomes the successful candidate and his/her party affiliation.

In any event, it appears that managed care/competition will continue to be favored by those who think it is the only cost-effective approach to universal health care coverage, and President Clinton has said that he will veto any bill that does not provide universal coverage.

As an organization, the Keystone Peer Review Organization has no particular position for or against health system reform or how it should be structured. But, if and when a program is passed, we strongly believe that it should include a provision for assuring the delivery of quality care, monitored by state-based, independent, quality improvement organizations. It will be interesting to see how all of this finally shakes out.

Dr. Harrop is president of the Keystone Peer Review Organization.

OBITUARIES

Edward B. Charney, MD, *Cherry Hill, NJ*
New York University School of Medicine, 1971; age 48, died February 6, 1994. Dr. Charney was a pediatrician.•

Francis A. Dineen, MD, *Pittsburgh*
Jefferson Medical College of Thomas Jefferson University, 1939; age 80, died April 7, 1994. Dr. Dineen was an internist.•

John J. Donovan, MD, *Pittsburgh*
Jefferson Medical College of Thomas Jefferson University, 1944; age 74, died February 23, 1994. Dr. Donovan was an internist.•

Sydney Davis II, MD, *Milton*
University of Pennsylvania School of Medicine, 1943; age 74, died March 6, 1994. Dr. Davis was a dermatologist.•

Samuel B. Fleagle, MD, *State College*
Georgetown University School of Medicine, 1941; age 80, died February 16, 1994. Dr. Fleagle was a general practitioner.•

Chauncey Hoffman, MD, *Johnstown*
Rush Medical College of Rush University, Illinois, 1937; age 88, died April 7, 1994. Dr. Hoffman was a family pracititoner.•

J. Warren Hundley, MD, *Bala Cynwyd*
University of Virginia School of Medicine, 1927; age 92, died March 23, 1994. Dr. Hundley was an internist.•

Robert G. Hunter, MD, *Jensen Beach, FL*
Jefferson Medical College of Thomas Jefferson University, 1950; age 73, died March 24, 1994. Dr. Hunter was a pathologist.•

Edward R. Janjigian, MD, *Kingston*
Age 84, died March 22, 1994. Dr. Janjigian was a neurologist.•

Frank E. Kulbaski, MD, *Ashley*
Hahnemann University School of Medicine, 1961; age 63, died March 31, 1994. Dr. Kulbaski was a radiologist.•

Robert L. Leopold, MD, *Haverford*
University of Pennsylvania School of Medicine, 1946; age 71, died April 9, 1994. Dr. Leopold was a psychiatrist.•

Angelo J. Maniglia, MD, *Altoona*
Hahnemann University School of Medicine, 1944; age 77, died March 28, 1994. Dr. Maniglia was an internist.•

Emroy A. Rittenhouse, MD, *East Lansing, MI*
University of Pittsburgh School of Medicine, 1936; age 83, died April 5, 1994. Dr. Rittenhouse was an otolaryngologist.•

Robert L. Sutton, MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1936; age 84, died March 22, 1994. Dr. Sutton was an internist.•

William C. Vernocy, MD, *Indiana*
University of Pittsburgh School of Medicine, 1936; age 81, died March 22, 1994. Dr. Vernocy was a general surgeon.•

George Chiao-Chi Wang, MD, *Drexel Hill*
Boston University School of Medicine, 1956; age 75, died March 30, 1994. Dr. Wang was a hematologist/oncologist.•

Janusz F. Winiarski, MD, *Hollidaysburg*
University of Freiburg, Germany, 1955; age 68, died March 22, 1994. Dr. Winiarski was an anesthesiologist.•

John P. Yukevich, MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1949; age 74, died April 5, 1994. Dr. Yukevich was a general practitioner.•

Robert Berger, DO, *Philadelphia*
Philadelphia College of Osteopathic Medicine, 1958; age 62, died February 14, 1994. Dr. Berger was a pediatrician.

Anthony F. Branella, MD, *Merion Station*
University of Rome, Italy, 1940; age 79, died April 4, 1994. Dr. Branella was an internist.

Richard H. Miller, MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1969; age 50, died March 23, 1994. Dr. Miller was a radiologist.

Josephine M. Stephens, MD, *Monongahela*
University of Pittsburgh School of Medicine, 1928; age 92, died April 6, 1994. Dr. Stephens was a pediatrician.

James A. Stewart, MD, *Pittsburgh*
Meharry Medical College School of Medicine, Tennessee, 1951; age 72, died March 30, 1994. Dr. Stewart was a general practitioner.

Ives C. Thillet, MD, *Philadelphia*
Age 65, died February 5, 1994. Dr. Thillet was a psychiatrist.

Bernard A. Tomassetti, *Boothwyn*
Jefferson Medical College of Thomas Jefferson University, 1945; age 74, died April 9, 1994. Dr. Tomassetti was an internist.

Johanna L. Wagner, MD, *Doylestown*
Temple University School of Medicine, 1949; age 78, died February 10, 1994. Dr. Wagner was an obstetrician/gynecologist.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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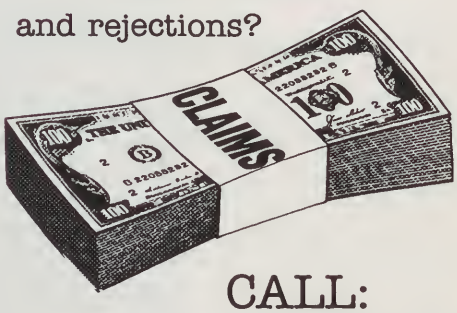

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Get Basic

George C. Manning, MD

Reprinted with permission from the *Bulletin of the Fort Wayne Medical Society,* Fort Wayne, Indiana, April 1994.

Let's face it. We are part of the problem. Every time we write a prescription which costs the patient $47, it is our fault. You do not find the parking lot at General Electric full of Mercedes, Lexus, and Lincolns, but you do at the doctors' parking lot at the hospital.

Not only that, but we are part of a special interest group, and there are only 350,000 non-federal practicing physicians—a pretty small number of votes in a nation of 265 million. Our patients may love us, but at any one time, only 15 percent of the nation are patients, and the rest of the people do not like doctors. These are the facts.

So forget our demands to Congress for special privileges in the health system reform package, even if they are good for our patients. As far as Congress, labor, and Big Business are concerned, we are potholes in the road to progress. The road needs to be patched, but not at the cost of pampering us.

Granted: Things are not good in the field of health care delivery. There is, however, one overriding issue—even though not only the president but the entire Congress is down-playing it over electioneering interests in "universal coverage," "employer mandates," "malpractice reform," "medical IRAs," and a lot of other systems trivialities. That one overriding concern, the one thing that put the whole "reform" process into motion, is *cost*.

That issue has two major subdivisions which have been the engines driving spending sky high: the federal government and the commercial health insurance industry (including HMOs, PPOs, etc.)—and they feed off each other. Neither Congress nor the president really want to face this fact (even though Hillary, for personal reasons, hates the insurance industry). We have to shove it in front of their faces—now. Congress is hard at work on our future.

"Health system reform" is an unconscionable hoax. Saving money on health care always has been number one on the agenda of the American voter. What Congress is giving us is universal coverage and a well-hidden, ever-increasing price tag.

Paradoxically, we could have universal coverage *and* save $300-$400 billion annually on health care *now*, without rationing, if Congress is really serious about doing the will of the people—and willing to overturn some deeply entrenched preconceptions.

What follows is the bare framework for true health system reform, the details of which I will supply anyone—in or out of Congress—on request.

Congress owes it to the voters to take a harder look at the overall structure of the health care plans in those nations that have established successful universal medical coverage. I say successful because most of those nations have a level of care nearly as good as we now enjoy in the United States, but at a maximum cost of only nine percent of their gross domestic product, compared to the 14 percent the U.S. spends today—before universalization. And 17 percent after cost savings, Hillary Clinton let slip a couple of months ago.

The distinguishing feature of successful foreign systems is the almost total lack of government and insurance micromanagement of caregiving by professionals. To emulate those countries, Congress needs to give us a near-total overhaul of the Health Care Financing Administration, parts of OSHA, and of the Federal Trade Commission—and of their regulatory structures.

It also needs to change the commercial health insurance industry so that up-front, dollar-specific, published indemnifications (not caps) for each specific service are mandated, and to remove from it any leeway to approve or disapprove professional health care decisions. "Managed care" has long since been proven to be the engine driving a huge portion of the health system cost increase. It takes dishonesty to deny it.

Write your senators and representatives, and tell them you want to save big bucks before they start "giving" us anything.

"'Health system reform' is an unconscionable hoax."

Dr. Manning, a retired neurosurgeon, is editor of the* Bulletin of the Fort Wayne Medical Society, *Fort Wayne, Indiana.

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References: 1. *A Report of the Surgeon General: Smoking and Health*, publication 79-50066. US Department of Health, Education, and Welfare. 1979. **2.** Bouknight LG, Bouknight RR: Cocaine—a particularly addictive drug. *Postgrad Med* 1988;83(4):115-131. **3.** Derlet RW: Cocaine intoxication. *Postgrad Med* 1989;86(5):245-253. **4.** Buchanan JF: Cocaine intoxication: A review of the presentation and treatment of medical complications. *Hospital Phys* 1988;3:24-28.

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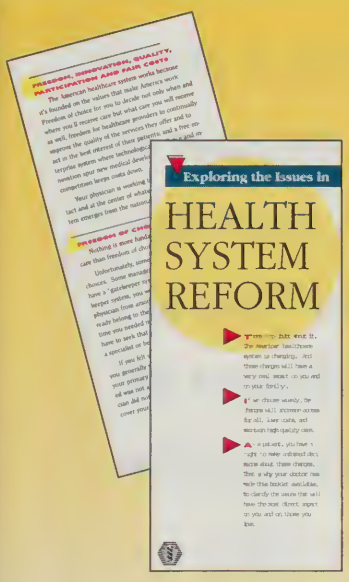

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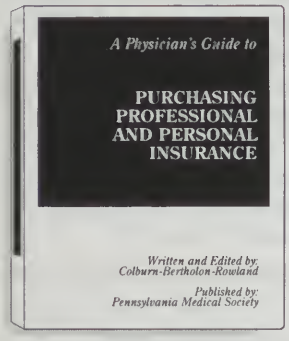

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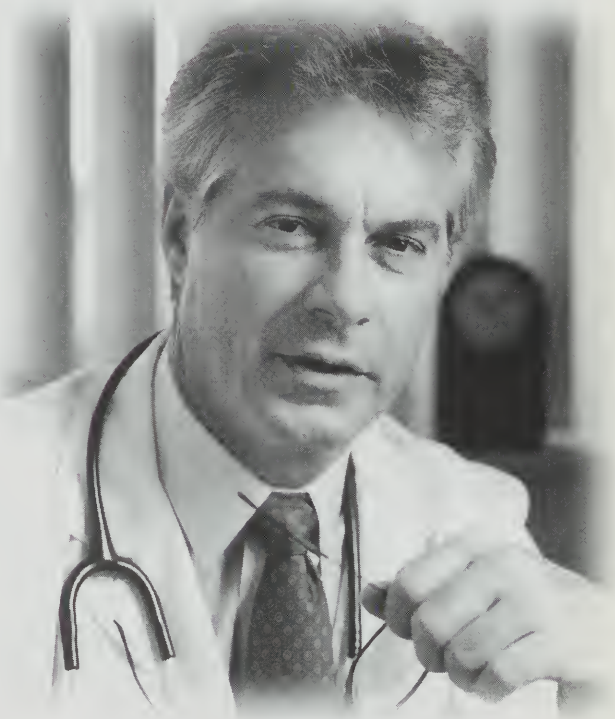
he was already sitting in my examining room. This guy was a walking liability suit looking for a victim. He was angry, non-compliant. It was one of those rare, no-win cases and, well, I guess my number was up.



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MEDIGRAM

DPW DRUG PRE-AUTHORIZATION PROGRAM DELAYED: At the request of the State Society, the Department of Public Welfare (DPW) has delayed until July 18 implementation of a new program requiring physicians to obtain a prior authorization number to be written on prescriptions for certain brand-name drugs for Medicaid recipients. The Society had a number of concerns about the program—most notably that physicians were not given timely notice of its implementation, originally scheduled for July 5. The Society is currently working to resolve other concerns.

The Society stresses that the new program does permit physicians to: 1) request an exception by calling (800) 558-2660, Monday-Friday, 9:00 a.m.-4:00 p.m.; and 2) prescribe a five-day emergency supply of a brand-name drug, only when prior authorization cannot be obtained because the department is closed (weekends, holidays, or after hours), by writing "emergency," as well as "brand name necessary," on the prescription. Direct any questions to the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

BUDGET PASSES WITHOUT PROVIDER TAX FOR ARBITRATION PANELS: The General Assembly, prior to its summer recess, passed a state budget that includes $706,000 to fund health care arbitration panels for 1994-95. The budget, on the governor's desk at press time, does not rely on a provider tax to fund the panels, as originally proposed. In other news, House Bill 1531, legislation which would permit a physical therapist to provide care to a patient without a prescription from a physician, was stalled in the Rules Committee. The Society opposes the bill, scheduled for House vote in the fall. Also, Senator James Rhoades (R-Schuylkill) has introduced a third-party claims bill drafted by the State Society.

MEDICAL LICENSE APPLICATIONS LOST IN HARRISBURG FIRE: The State Board of Medicine has estimated that a half-dozen applications for unrestricted full medical licenses were lost in the mid-June fire at the State Transportation Building, Harrisburg, which housed the board's offices. Physicians who sent in applications shortly before the fire may check their status by calling the board at (717) 783-1400.

PHYSICIANS DECLINE EXECUTION TASK: At press time, Pennsylvania officials were still in search of a physician to prescribe the lethal combination of drugs and pronounce death in the state's first execution in 32 years, that of convicted murderer Joseph Thomas Szuchon. The AMA, American College of Physicians, American Nurses Association, and American Public Health Association say such actions are unethical. In related news, Senator Robert Jubelirer (R-Blair) has introduced a bill repealing the requirement that a "licensed physician" declare death when a sentence is carried out by lethal injection.

AMA HOUSE ADOPTS SIX PENNSYLVANIA RESOLUTIONS: The AMA House of Delegates at its annual meeting in June adopted six of 10 resolutions offered by the Pennsylvania Delegation to the AMA. Three other resolutions were addressed in reports adopted in lieu of the resolutions; one resolution was referred to the AMA board. Look for details in the September issue of PENNSYLVANIA MEDICINE.

In elections: Lee H. McCormick, MD, was re-elected chair of the AMA-HMSS Governing Council, and William H. Mahood, MD, was re-elected to the AMA Council on Medical Service. Jonathan E. Rhoads Jr., MD, was unsuccessful in Pennsylvania's effort to obtain a seat on the AMA board. Also at the meeting, Donald G. Ferguson, MD, was elected to the board of the Organization of State Medical Association Presidents.

HCFA RELEASING MEDICARE SURVEY THIS MONTH: The Health Care Financing Administration (HCFA) this month will release a nationwide survey to measure and evaluate physicians' satisfaction with their Medicare carriers. HCFA says the survey—to be mailed to a random selection of physicians in each service area—should take only 15 minutes to complete, and cover issues related to claims processing, service, and appeals. Physicians who are asked to participate are urged to do so.

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Medical Education: *Disease Prevention Should Be Other Half*

John W. Mills, MD
Medical Editor

Some months, editorial ideas are easy to come by; yet, at other times, I have to rack my brain to come up with something I can really build an editorial around. Occasionally, an idea smolders for a time, then suddenly bursts into an editorial piece. A conversation between two physicians (an ob/gyn and a surgeon) several weeks ago provided a nucleus for this month's editorial. Perhaps the nature of their specialties had a bearing on their comments, but I was struck by the *lack* of preventive medicine awareness in their exchange.

It had been mentioned that the patient about to undergo surgery was a chronic heavy smoker and a poor risk for the emergency cholecystectomy. The surgeon indicated he didn't feel it was his place to interfere with his patient's "rights," and if the patient wished to smoke, that was his business. The ob/gyn agreed wholeheartedly and noted that he never felt it was his duty to broach the subject of smoking with his patients—it was their "right" and business.

"We have a costly system that is not too efficient, and we stress little in the way of prevention of illness."

This really blew my mind! As physicians, we should know what effects poor habits or a poor diet can have on our individual patients. We also have an obligation and a duty to make that information available to our patients. If they ignore our warnings and our information, we should not acquiesce, but continue to discuss and reason with them in hopes of a change for the better.

In the past few months, our country's medical schools graduated the newest crop of MDs and DOs. What has been the main emphasis in their medical training? I don't think it has basically changed since I graduated 41 years ago—our newest members of the profession are acutely trained to diagnose and cure disease. However, this seems to me to be only half of the equation. Prevention of disease should be the other half of medical education.

We do have the finest health care system in the world overall, but as I've noted on these pages before, we have our problems. We have a costly system that is not too efficient, and we stress little in the way of prevention of illness. This has really come to the fore recently with all the publicity over tobacco-related health problems. Witness the huge costs related to substance abuse in our country—from crack babies to domestic violence to automobile fatalities. The numbers are mind-boggling, both in how many people are involved or affected, and in the costs attributed to health care.

I'm always behind in my reading—thus, I keep piles around the house "to eventually get to," much to my wife's consternation! Just recently, I picked up the February 1994 issue of *Prevention Magazine*, and Mark Brinklin's editorial, "The Power of Pro-Active Prevention," struck a responsive chord. As a reader of *Prevention Magazine* for many years, I've watched it evolve into a respectable and responsible publication. In fact, I had it in my waiting room for years.

It is published by a group from Emmaus, Pennsylvania, who gave us the "People's Medical Society" and who have, at times, "roughed up" our profession. Yet, I feel they serve a need, and their emphasis on the prevention aspects of health care cannot and *should not* be ignored.

Some startling statistics are noted in Brinklin's editorial, citing some impressive savings from prevention of disease and promotion of healthy lifestyles. One example is the impressive work of Dean Ornish, MD, of California. He has established a working model of how to live a very healthy lifestyle at a retreat-like setting. Low-fat diets, proper exercise, and stress-relieving sessions are taught and practiced. Dr. Ornish has clearly established that his lifestyle program can reverse coronary disease, opening up blocked arteries. Coronary disease is often linked with emotional stress. Responding with anger, depression, and hostility are danger signals.

We pride ourselves on being our patients' advocates. Let's really live up to that by helping our patients prevent illness, with a pro-active stance!

LETTERS TO THE EDITOR

CHANGE COMING, UNDERSTANDING NEEDED

I am a member of the Pennsylvania Medical Society and also a reader of PENNSYLVANIA MEDICINE. I was somewhat shocked by the strident and angry tone of President Murcek's editorial on page 8 of the May 1994 issue. I certainly do not deny Dr. Murcek's right to his opinion. I feel, however, that his tone was inappropriate for that of the president of a prominent medical organization.

He himself refers to a *Philadelphia Inquirer* editorial as "mean spirited, childish, and hypocritical," as well as "name calling and holier than thou."

Dr. Murcek goes on to talk about totally extraneous affairs, such as the Whitewater matter. In the first place, we don't know what, if anything, is going to come out of Whitewater, and in the second place, what in the world does it have to do with health care? He refers to the First Lady as "Saint Hillary" and finishes by talking about the "ingrates serving as mouthpieces for the Clintons' flawed plan."

I think it is time we forget about all of this overheated language. We must face the fact that we as physicians, as well as other segments of our population, have got to come to some kind of consensus on providing all of the people of our country with a basic set of health benefits, while preserving the integrity of organized medicine. Such language as Dr. Murcek uses in his writings does not help, but rather fans the flames of a public that is already suspicious of physicians' motives regarding this entire issue.

I am not saying that everything that President and Mrs. Clinton have suggested or mentioned is appropriate. It appears that very little of the president's plan will survive in its current form. However, like it or not, major change is coming. We must all go to the table in the spirit of understanding and compromise. We cannot let our anger and overheated, zealous protection of our past prerogatives blind us to the need of meaningful and cool-headed dialogue.

Andrew Newman, MD, JD
Bala Cynwyd

PEDIATRICIANS OFFER THANKS

Thank you for publishing "Project Seeks to Bolster Immunizations,"an article on the Statewide Immunization Information System Project, in the May 1994 issue of PENNSYLVANIA MEDICINE [page 30]. The Pennsylvania Chapter of the American Academy of Pediatrics appreciates this opportunity to educate Pennsylvania physicians about the project.

Over the next several years, we will provide primary care practices with information on the value of "tracking systems" to improve the quality and completeness of primary care. We hope PENNSYLVANIA MEDICINE will play an important role in this dissemination.

Jerold M. Aronson, MD
President, Pennsylvania Chapter
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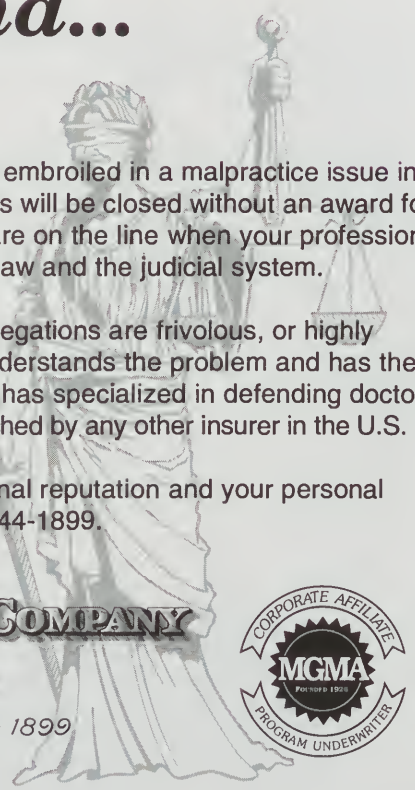

HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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The Power of the Press

Martin A. Murcek, MD

The power of the press—I should know something about it. My son Bud began his career as a reporter at our local paper, the *Greensburg Tribune Review*. He has since moved to a communications firm in Greensburg, but I well remember his days as our young Clark Kent.

The power of the press—I was reminded of it again at the end of March when that same local paper carried a four-part "Special Report" on "bad" doctors. The page one series, which started on a Sunday (the week's most widely read edition) had the physician community in an uproar.

The series examined four different aspects of "bad" doctors: the responsibility of the State Board of Medicine, the problems of impaired physicians and the help available to them, the problems of malpractice and the lack of public access to malpractice information, and ways to improve the "bad-doctor" situation. There were several parts of the series that concerned local physicians, but a few stood out.

First, the reporter seemed to imply that physicians are unwilling to police themselves and weren't concerned about the well-being of the impaired-physician's patients. That's just not true.

Second, the reporter used old cases, most from 10 years ago or more, as examples in his story. They were the same old stories we all know about: Most of the impaired physicians in the story had successfully undergone treatment, and the malpractice cases had been resolved in our legal system.

And last, one of the malpractice examples included a local physician of the highest caliber, a respected member of the Greensburg-area medical community for years. It seemed to imply that the physician was a "bad apple"; nothing could be further from the truth.

The power of the press—I was reminded of it as physicians met in the halls of our local hospital discussing how to respond to an article that they viewed as an attack on our profession, our integrity, and our compassion.

As president of this Society, I immediately wrote a "Letter to the Editor" in response to the series. I'd like to share with you part of that letter, which appeared on the editorial page on Easter Sunday (see text, at left).

The power of the press—I was reminded of it as I read my response on the editorial page and heard my colleagues' thanks at every turn in my hospital rounds the next week. And it reminded me that part of the "power" is in the public's opportunity to respond to what is printed.

I still wish the story had been written differently, more constructively. We all acknowledge that problems do exist. But I'm not a reporter, I'm a physician...a physician who is proud of the work we do and the ideals for which we stand, for our commitment to identifying problems and trying to solve them. But mostly for our dedication to always keeping the welfare of our patients as our first priority. ⬡

Dear Editor: I must respond to your recent special report, "Physician Heal Thyself," which ran from March 20-23. I am concerned that the tone of the story seemed to suggest that physicians aren't concerned about the well-being of their colleagues with substance abuse problems and the resulting well-being of their colleagues' patients. Nothing could be further from the truth.

Doctors are in the business of caring for people, of helping them live their lives to the fullest possible extent. That caring doesn't stop with our own personal patients—it extends to the health of our fellow professionals.

That is why I am proud of the Pennsylvania Medical Society's pioneering Physicians' Health Programs, which provide rehabilitation services to impaired physicians in this state. This effort has been a model for the nation. Many experts who have examined the relatively low rate of disciplinary action against physicians in Pennsylvania believe it is because we do have a quality program that helps physicians correct their substance abuse problems.

Of course, there is no program that reaches all the physicians in trouble, and certainly, there are some [physicians] who are not interested in receiving help. That is why we need a strong State Board of Medicine. The Pennsylvania Medical Society has filed not one, but two separate lawsuits against the state government in an effort to get a mandate that revenue from medical licensing fees be applied to the board's investigation and enforcement efforts. And we would support efforts to further strengthen the board.

Your series carried more than a hint of prejudice against professionals with impairments. It only makes sense that we as a society first assume that they are deserving of the chance to get clean and get on with their lives. And believe me, that is what most of them do. Physicians are as deserving as anyone else to be given that chance, [and we] have been at the forefront of the effort to help our colleagues overcome substance abuse problems and return to safe, productive roles.

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NPDB: What Physicians Don't Know Can Hurt Them

Raymond N. Ankney
James A. Coil, MD
Jacob Kolff, MD
Eduardo Esper, MD

A 1993 survey of State Society members finds significant confusion and misunderstanding about the National Practitioner Data Bank.

National Practitioner Data Bank (NPDB) reports have serious ramifications because they are part of privileging, credentialing, and licensing for a physician's entire career. But a recent randomized sampling of 1,410 Pennsylvania Medical Society members in private practice found significant confusion about NPDB.

Eighty-one percent of respondents did not know that denial of initial license application was not a reportable offense. Sixty-nine percent did not know that voluntary entrance into alcohol or drug rehabilitation was not reportable. Seventy-five percent did not know denial of expanded privileges because of lack of clinical competence was reportable. Only 13 percent knew how to obtain their NPDB reports.

The survey suggests physicians have a poor understanding of NPDB, even though these reports can have career-jeopardizing implications.

Misinformation abounds

The random survey, sent in October 1993, found tremendous misinformation about NPDB among physicians: More than 200 respondents believed the NPDB was a registry of licensed physicians; 150 thought it was a registry listing every physician's address, medical school, residency training, and specialty; and 53 respondents asserted it was an FBI registry of physicians with felony convictions.

In regard to access to the data bank, 53 percent of respondents did not know that consumer groups and the general public do not have access to NPDB information, while 46 percent believed colleagues and competitors could review any physician's file (see Table 1, opposite page).

Responding physicians also did not understand the reasons for NPDB reports. Seventy-five percent were unaware that denial of expanded privileges because of lack of clinical competence was reportable, and 33 percent did not know denial of license renewal was reportable. Thirty-seven percent did not know that physicians are reported for malpractice payments and judgments, and 23 percent did not know that adverse actions on privileges, licensures, and society memberships over 30 days are reportable offenses.

Finally, high percentages of respondents incorrectly believed that physicians could be reported for medical record violations, voluntary entrance into alcohol and drug rehabilitation, denial of initial license application, retirement, repeated traffic offenses, and higher-than-expected complication rates (see Table 2, opposite page).

We also were surprised that only a small percentage of physicians knew how to obtain their NPDB reports: Just 13 percent of respondents knew to contact the Health Resources and Services Administration or Unisys, a contractor that runs NPDB, to obtain data bank information.

If you think we're confused...

The survey findings indicate confusion and misinformation about NPDB that could become more important if consumer groups and the general public are given access to NPDB for providers with two or more files, as proposed by the Clinton Administration.[1] Although the general public should have information on substandard practitioners, there are several potential problems with the Clinton proposal.

For example, adverse action rates in New York and Mississippi differ by a factor of 10, while the clinical privilege action rates vary from 0.7 in Illinois to 3.6 in Arizona.[2] Moreover, medical malpractice rates differ for specialties and states. For example, 73 percent of obstetricians/gynecologists have been sued once with the "average" obstetrician reporting eight lawsuits.[3]

Another issue is that the military and Department of Veterans Affairs only report physicians to NPDB if they don't meet

Mr. Ankney is medical editor, Department of Surgery, Conemaugh Memorial Hospital, Johnstown. Dr. Coil is program director of the hospital's General Surgery Residency Program, Dr. Kolff is chairman of the Department of Surgery, and Dr. Esper is the chief general surgery resident.
The authors thank John Davis of the Applied Research Lab at Indiana University of Pennsylvania for his statistical analyses.

the "standard of care." This review process is not offered to civilian physicians. As of June 1992, the 40,000 practicing physicians and residents of the VA system had suffered just two NPDB files.[4]

All of these factors will affect how many NPDB reports a physician has. Will consumers understand that Dr. Smith has no data bank reports because he has been in the VA system for the last four years? Will they comprehend that Dr. Jones doesn't have an NPDB file because she just left residency? Will they know that Dr. Rogers has more reports because he previously worked in a litigious state or an area with an active licensing board?

If the president's proposal is implemented, physicians with two small malpractice settlements could have this information published in the local newspaper. Competitors then could use these data to portray physicians as incompetent. →

Table 1

Access to NPDB

	Yes (%)	No (%)	Not Sure (%)	% Answering Incorrectly
Can a colleague/competitor review your data bank file outside of peer review?	55 (14)	216 (54)†	132 (33)	47
Can hospitals review the data bank files of staff members/applicants?	314 (78)†	14 (3)	76 (19)	22
Do consumer groups and the general public have access to NPDB?	90 (22)	191 (47)†	122 (30)	52
Can the state licensing board review a physician's file?	324 (80)†	4 (1)	76 (19)	20
Can a physician appeal an NPDB report?	265 (66)†	22 (5)	117 (29)	34
Have you examined your file?	31 (8)	365 (91)	7 (2)	N/A

† *correct answer*

Table 2

Reasons for NPDB Reports

	Yes (%)	No (%)	Not Sure (%)	% Answering Incorrectly
Are physicians reported for all malpractice judgments and settlements?	252 (63)†	49 (12)	98 (24)	36
Are physicians reported for adverse actions over 30 days?	311 (77)†	5 (1)	87 (22)	23
Are physicians reported for suspension of privileges because of medical record violations?	98 (24)	181 (45)†	125 (31)	55
Are physicians reported for voluntary entrance into alcohol/drug rehabilitation?	76 (19)	124 (31)†	204 (50)	69
Are physicians reported for privilege denial because they don't meet a facility's required threshold for performing a procedure?	46 (12)	212 (53)†	145 (36)	48
Are physicians reported for denial of expanded privileges because of lack of clinical competence?	98 (24)†	147 (36)	158 (39)	75
Are physicians reported for surrendering privileges because of personal reasons, infirmity, retirement?	74 (18)	176 (44)†	154 (38)	56
Are physicians reported for denial of license renewal?	269 (67)†	19 (5)	116 (29)	34
Are physicians reported for denial of initial license application?	155 (38)	76 (19)†	173 (43)	81
Are physicians reported for repeated traffic citations?	5 (1)	269 (67)†	129 (32)	33
Are physicians reported for having a higher-than-expected complication rate?	62 (15)	179 (44)†	162 (40)	55

† *correct answer*

This situation is worrisome because the link between malpractice suits and physician negligence is tenuous.

Physicians are urged to understand what constitutes a reportable offense, review the law's due process, and maintain legal counsel when dealing with a malpractice case or adverse action situation.

So, exactly what is NPDB?

The Health Care Quality Improvement Act of 1986 required the Health Resources and Services Administration (HRSA) to establish a national computerized database of physicians and dentists who settle or lose malpractice claims, or who suffer adverse actions on licensure, privileges, and society memberships.[5-9] Four years later, NPDB began collecting information.

Any health care organization, insurer, or self-insured practitioner that paid to settle a malpractice suit after September 1, 1990, was required to report this information to NPDB and the state licensing board within 30 days. In addition, adverse actions on licensure, clinical privileges, and society memberships exceeding 30 days became reportable offenses. NPDB's report lists the practitioner's age; a short description of the diagnosis and treatment; and the settlement, judgment, or adverse action.[10]

HRSA considers residents and interns as trainees in graduate health professions education and generally does not require reporting of adverse actions on privileges and society memberships. Even residents who are fired are not reported to NPDB. Moreover, residents who strike patients have not committed reportable offenses. However, adverse license actions by state medical boards are reportable.[11]

Adverse privilege actions against residents and interns can only be reported in one instance: If the physician practices outside his or her graduate education program. A surgical resident who moonlights in the emergency room and suffers an adverse action as part of a professional review would be reported to NPDB.

The act also mandates that:

- malpractice payments and judgments made because of care provided by residents and interns be reported[12];
- hospitals obtain the data bank files for applicants seeking staff appointments and clinical privileges; and
- hospitals review the data bank files of staff members every two years.[13]

Supporters of NPDB maintain that it prevents poor health care practitioners from relocating and gaining clinical privileges without disclosing prior malpractice payments and adverse actions. One published article reported 6,000 "gypsy" physicians who leave hospitals to avoid disciplinary actions.[14]

The U.S. Department of Health and Human Services surveyed hospital credentialing committees to examine whether NPDB assisted with their reviews. Committee members claimed that 47 percent of reports contained information that physicians or dentists failed to give, and 40 percent of committee members said NPDB reports offered insights into practitioner qualifications that were not available from other sources.[15]

Some medical associations counter, however, that NPDB punishes providers who lose small malpractice cases. The majority of reports, they argue, occur because insurance carriers settle "nuisance suits" for a few thousand dollars. Since the act requires reporting of all settlements and judgments, physicians can provide quality care, but be reported because insurers don't want to risk litigation.[16]

→

Key Survey Results

The survey included 21 multiple choice questions, each worth one point. Statistical analyses examined the relationship of age, years in practice, sex, place of medical school graduation, county residency, and specialty, to NPDB knowledge:

- Physicians under 40 years of age scored a mean of 8.59, physicians aged 41 to 45 years reported a mean of 9.22, and physicians aged 56 years and older had a mean of 8.30.
- Years in practice did not affect physician understanding of NPDB. Physicians who practiced 0 to 10 years had a mean of 8.54, physicians who worked 11 to 20 years had a mean of 9.45, and physicians who served 21 years and greater had a mean of 8.58.
- Male physicians scored a mean of 8.91, while female physicians had a mean of 7.87.
- There were some small, but statistically insignificant, differences by physician specialty.
- U.S. medical school graduates had a mean of 8.71, and foreign medical school graduates had a mean of 9.23.
- Physicians in Philadelphia and Allegheny County, the two largest urban areas in Pennsylvania, scored poorer than physicians from other areas. Philadelphia physicians had a mean of 7.99, Allegheny physicians had a mean of 8.27, and physicians from other counties had a mean of 9.17.
- The only other factor of statistical significance was prior NPDB reports: Physicians who had at least one data bank file scored a mean of 11.06 on the questionnaire, while physicians who did not have a file, or were unsure of their data bank history, reported a mean of 8.58.

Demographics of survey respondents

- 404 physicians covering 47 specialties and 40 counties responded to the survey.
- 119 respondents were under 40 years of age, 163 were aged 40 to 55, and 119 were aged 56 and older.
- 337 respondents were U.S. medical school graduates, and 60 were foreign medical school graduates.
- 354 respondents were male; 48 were female.

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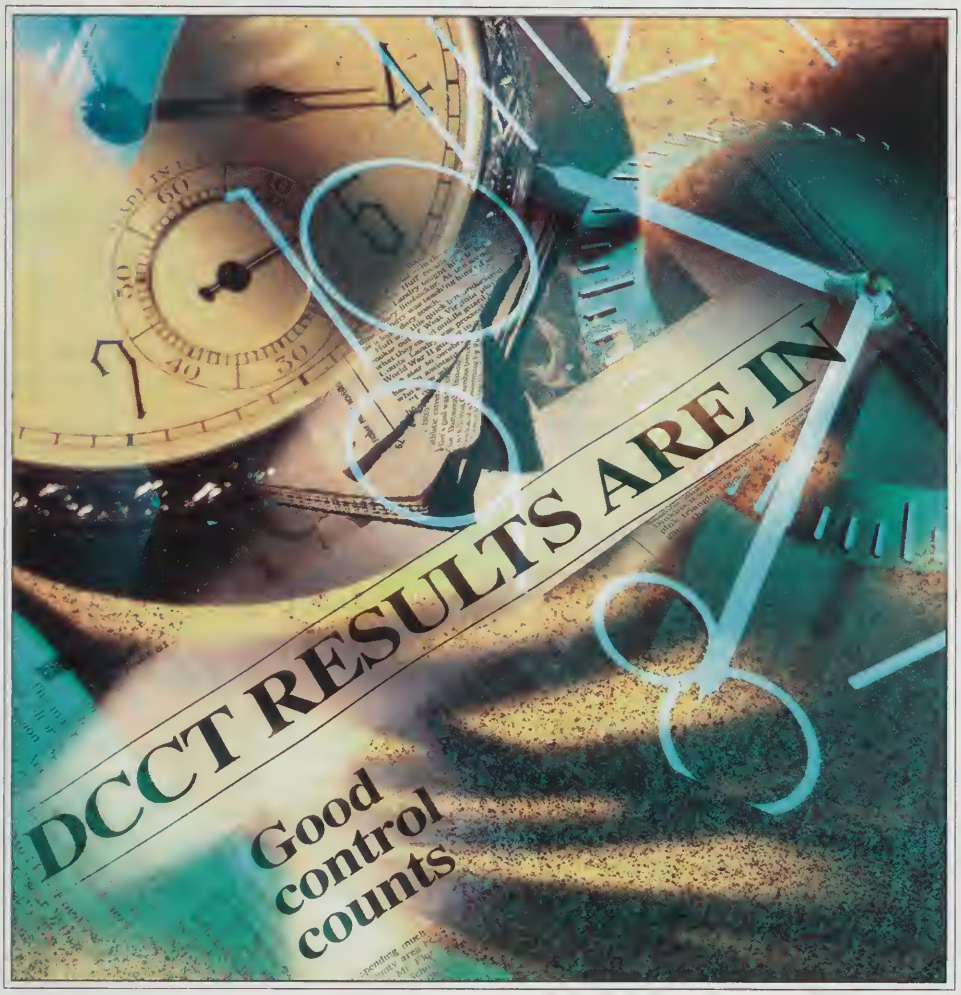

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Since September 1, 1990, NPDB has collected 74,913 reports on physicians and dentists, including 62,415 malpractice payments and 7,369 adverse actions.[17]

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What Physicians Need to Know About the National Practitioner Data Bank

State Society experience has shown that physicians may not be fully aware of the National Practitioner Data Bank's policies and procedures until it is too late—until they receive notice of being reported to the data bank. The editors offer the following Q&A, compiled from various Society publications and files, as information for members.

What is the National Practitioner Data Bank (NPDB)?

NPDB was established by the Health Care Quality Improvement Act of 1986, which sought to encourage health care practitioners to identify and discipline those who engage in unprofessional behavior, and to restrict incompetent health care practitioners from moving from state to state without disclosure or discovery of the practitioner's previous incompetent performance.

Opened in September 1990, NPDB collects information on the professional competence and conduct of physicians and other health care practitioners. Reportable information includes: medical malpractice payments, adverse actions on clinical privileges, adverse licensure actions, and adverse actions on professional society memberships.

Who can access data bank information?

Though the information collected is confidential and only released to authorized entities—hospitals and other health care institutions, state licensing boards, and physicians—President Clinton's health system reform plan proposes to open the data bank to the public. The idea distresses the Federation of Medicine, which has voiced several concerns to the data bank even prior to its opening.

What are those concerns?

Among concerns cited by the AMA are:

- *Confidentiality:* NPDB has not established detailed procedures to determine whether a requesting entity meets the statutory prerequisites for access.
- *Excessive collection and retention of nongermane information:* The AMA opposes collection and retention of information on physicians for whom no adverse reports have been received.
- *Medical malpractice payments:* The AMA maintains that settlement of a lawsuit does not necessarily constitute malpractice, and questions the accuracy and consistency in reporting such information.

Further, more than once since 1990, the AMA House of Delegates has voted to urge Congress to dissolve NPDB, so far without success.

While the State Society agrees with many of the AMA's concerns, it has spent a great deal of time educating authorized users of the data bank that NPDB information should be considered together with *other* relevant data in evaluating a practitioner's credentials.

What if a physician disagrees with a data bank report?

To dispute the accuracy of information reported to the data bank, write the reason for the disagreement with the report on the back of the Practitioner Notification Document you receive from the data bank, and return it to NPDB at P.O. Box 6048, Camarillo, CA 93011-6048.

How can a physician find out what information is in the data bank about himself or herself?

To self-query the data bank, submit a Request for Information Disclosure form, available from the data bank, to NPDB at P.O. Box 6050, Camarillo, CA 93011-6050. There is a fee for this service.

What if I have further questions?

NPDB offers a toll-free Data Bank Help Line: (800) 767-6732. Also, members may call the Society's Department of Medical Staff Relations at (800) 228-7823 or (717) 558-7750, ext. 457, for further information.

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New Therapeutic Agents Marketed in 1993

This is the fourth and final in a series of articles overviewing new drugs marketed in the U.S. in 1993.

Daniel A. Hussar, PhD
Remington Professor of Pharmacy
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In 1993, the Food and Drug Administration (FDA) approved 25 new molecular entities (NMEs), 23 of which are for therapeutic use and two are diagnostic agents. Eleven of the NMEs for therapeutic use, as well a new biological agent intended for therapeutic use, were both approved and marketed in the United States in 1993. In addition, 11 other NMEs that the FDA approved before 1993 (most in late 1992) were marketed during the year. Thus, a total of 23 therapeutic agents reached the U.S. market for the first time in 1993, a considerably lower number than the 30 new therapeutic agents marketed in 1992 and the record number 31 new agents marketed in 1991. Many of the 13 therapeutic agents approved in 1993 but not marketed before the end of the year have become available in early 1994.

Of the 23 new therapeutic agents first marketed in 1993, 22 are considered in this series. The one agent not reviewed is flosequinan, which was withdrawn from the market after being available only several months because of a concern about toxicity.

This review considers the new agents' most important properties and, when possible, compares them with other available agents with similar properties. When additional information is needed, more comprehensive references and the product literature should be consulted.

Antiasthmatic agent

Nedocromil sodium (Tilade-Fisons; Rhone-Poulenc Rorer) is an anti-inflammatory agent that is administered by oral inhalation for the preventive management of asthma. The actions of the new drug are most similar to those of cromolyn sodium (Intal), although the two drugs are structurally different.

Nedocromil appears to inhibit the activation and release of mediators from various inflammatory cell types associated with asthma such as eosinophils, neutrophils, macrophages, mast cells, monocytes, and platelets. It inhibits the bronchoconstrictor response to challenges such as inhaled irritants, exercise, and cold air, and is effective in reducing the inflammation of the lining of the airways that is associated with asthma. The drug has no bronchodilator, antihistamine, or glucocorticoid activity.

The specific indication for nedocromil is for maintenance therapy in the management of patients with mild to moderate bronchial asthma. The new drug may be particularly useful in asthmatic patients who need the use of a beta-adrenergic agonist bronchodilator (e.g., albuterol [Proventil, Ventolin]) more than three times a week. In the clinical studies, nedocromil was shown to be significantly superior to placebo in relieving symptoms and improving pulmonary function. In allergic asthmatics who are well controlled on cromolyn, there is no evidence that the use of nedocromil instead of cromolyn would provide additional benefit for the patient.

Because nedocromil is not a bronchodilator, it should not be used for the reversal of acute bronchospasm, particularly status asthmaticus. Patients who are being treated with nedocromil who experience asthma episodes should continue use of the drug, unless the patient cannot tolerate inhaled medications.

When administered by oral inhalation, the systemic bioavailability of nedocromil is low, and it is unlikely to cause systemic adverse reactions. Only unpleasant taste occurred significantly more often in nedocromil-treated patients than in placebo-treated patients, and this effect may be lessened by using a pleasantly flavored mouthwash immediately after administration of a dose.

The recommended dosage of nedocromil for symptomatic adults and children 12 years of age and older is two inhalations four times a day at regular intervals to provide 14 mg of the drug per day. In patients who are under good control on four-times-daily dosing, a lower dose can be tried. Nedocromil should first be reduced to a three-times-daily regimen (10.5 mg per day) and then, after several weeks on continued good control, to twice a day (7 mg per day). Nedocromil should be added to the patient's existing treatment regimen (e.g., bronchodilators). When a clinical response to nedocromil is evident, and if the asthma is under good control, an attempt may be made to decrease the concomitant medication usage gradually.

To obtain the optimum benefit of nedocromil therapy, patients should be informed of the importance of administering the medication at the regular interval that is recommended, even during symptom-free periods. Patients should also be instructed regarding the method for administering the drug.

Nedocromil sodium is supplied in a metered-dose inhaler with a plastic mouthpiece. Each inhaler provides at least 112 metered inhalations, and each actuation delivers 1.75 mg of the drug from the mouthpiece.

Gastrointestinal prokinetic agent

Cisapride (Propulsid-Janssen) is a prokinetic agent that restores, normalizes, and increases motility in the gastrointestinal tract. It is structurally related to metoclopramide (Reglan) and shares certain pharmacologic actions with this agent. However, unlike metoclopramide, cisapride is not likely to antagonize dopamine receptors (antidopaminergic action) which has been responsible for certain adverse effects (e.g., extrapyramidal reactions) associated with the use of metoclopramide. The primary mechanism of action of cisapride is thought to be enhancement of the release of acetylcholine at the myenteric plexus.

Cisapride is indicated for the symptomatic treatment of patients with nocturnal heartburn due to gastroesophageal reflux disease (GERD). Nocturnal heartburn in GERD patients is primarily a motility disorder, and hypersecretion of acid is not often a factor. The new drug has been reported in clinical studies to be as effective or more effective than other agents in reducing

nocturnal heartburn, and the following actions are probably responsible for its beneficial effects:

- increases lower esophageal sphincter pressure (LESP) that helps to reestablish the esophageal barrier;
- improves esophageal peristalsis that assists in the clearance of acidic materials; and
- promotes gastric emptying that reduces back pressure on the lower esophageal sphincter.

In other studies, cisapride has also been reported to be effective in reducing other symptoms associated with GERD, as well as in various motility disorders, including reflux esophagitis, gastroparesis, nonulcer dyspepsia, and constipation. Although these are not labeled indications for the drug at the present time, it is anticipated that the indications for cisapride will expand as additional studies are completed. Unlike metoclopramide, cisapride does not exhibit antiemetic activity.

The acceleration of gastric emptying caused by cisapride may affect the rate of absorption of other drugs. For example, the sedative effects of benzodiazepines (e.g., diazepam [Valium]) and alcohol may be potentiated by cisapride, and patients should be advised of this possibility. Patients receiving other drugs that require careful titration should be followed closely; if serum concentrations are being monitored, they should be reassessed. In patients receiving anticoagulants, it is recommended that coagulation times be checked one week after the start and discontinuation of cisapride therapy.

The recommended initial adult dosage of cisapride is 10 mg four times daily at least 15 minutes before meals and at bedtime. In some patients the dosage will need to be increased to 20 mg four times a day. Cisapride capsules are supplied in a 10-mg potency.

Antineoplastic agents

Paclitaxel (Taxol-Mead Johnson Oncology) is a natural product that is extracted from the bark of the Pacific yew tree. Until several years ago, the quantity of the drug that could be obtained was so small that the opportunities to evaluate its use in patients were very limited. However, more recently, primarily as a result of identifying additional sources for the drug and the development of better extraction methods, the supply of the drug has been sufficient to meet the need for clinical use and continuing investigations.

Paclitaxel is poorly soluble in water, and the concentrate in which it is supplied is a nonaqueous solution containing dehydrated alcohol (49.7 percent v/v) and a nonionic surfactant, polyoxyethylated castor oil (Cremophor EL) that is used as a solubilizing agent. This concentrate is diluted with a suitable parenteral fluid prior to intravenous infusion.

The indication for which paclitaxel has been approved is the treatment of metastatic carcinoma of the ovary, after failure of first-line or subsequent chemotherapy. The standard treatment for advanced ovarian cancer is a platinum-based agent (cisplatin [Platinol] or carboplatin [Paraplatin]) plus cyclophosphamide (Cytoxan). In the clinical studies with paclitaxel, about one-fourth to one-third of the patients responded to the new drug (most with a partial response), including some who had developed resistance to platinum-containing therapy. Although many patients have not responded to the use of paclitaxel, the benefit the new drug has provided in a number of patients with advanced or refractory ovarian cancer has been the basis for some to advocate that it be used in first-line regimens (e.g., with cisplatin) in the management of advanced ovarian cancers.

The use of paclitaxel is also being evaluated in the treatment of other cancers such as advanced breast cancer, non-small cell lung cancer, head and neck cancer, and malignant melanoma. However, these are not labeled indications for the drug at the present time.

Like other antineoplastic drugs, paclitaxel causes adverse reactions in a high percentage of patients. Bone marrow suppression (e.g., neutropenia and thrombocytopenia, and the resultant risks of infection and bleeding) is the major dose limiting toxicity and appears to be more frequent and more severe for patients who have received prior radiation therapy. The use of paclitaxel is contraindicated in patients with baseline neutropenia of <1,500 cells/mm^3, and it is recommended that all patients treated with the drug have frequent peripheral blood counts performed.

The use of paclitaxel has been associated with a high incidence (41 percent) of hypersensitivity reactions. Severe reactions characterized by dyspnea, hypotension, angioedema, and generalized urticaria have occurred in two percent of patients and, to reduce the risk of such reactions, all patients who are to be treated with the new drug should be premedicated with a corticosteroid (e.g., 20 mg of dexamethasone [Decadron] orally about 12 hours before and six hours before), antihistamine (e.g., 50 mg of diphenhydramine [Benadryl] intravenously 30 to 60 minutes before), and a histamine H_2-receptor antagonist (e.g., 300 mg of cimetidine [Tagamet] or 50 mg of ranitidine [Zantac] intravenously 30 to 60 minutes before).

It is likely that some of the hypersensitivity reactions experienced are due to the Cremophor EL component of the formulation rather than to paclitaxel. Therefore, the use of paclitaxel is contraindicated not only in patients who have a history of hypersensitivity reactions to the new drug, but also in individuals with a history of such reactions to other drugs that are available in formulations containing Cremophor EL (e.g., cyclosporine [Sandimmune], teniposide [Vumon]).

Peripheral neuropathy was reported in 62 percent of the patients treated with paclitaxel, with four percent of patients experiencing severe neurologic symptoms. When severe symptoms occur, it is recommended that the dosage of paclitaxel used in subsequent courses of therapy be reduced by 20 percent. Other adverse reactions that have been experienced by more than 50 percent of patients include arthralgia/myalgia, nausea and vomiting, and alopecia.

The usual dosage of paclitaxel is 135 mg/m^2 administered by intravenous infusion over 24 hours every three weeks (an alternative regimen of 175 mg/m^2 infused over a three-hour period is being evaluated). The neutrophil and platelet counts, as well as the occurrence of adverse reactions such as peripheral neuropathy, should be evaluated in the determination of the interval between courses of therapy and/or the amount of subsequent doses.

Paclitaxel concentrate is supplied in single-dose vials containing 30 mg of the drug per 5 ml. The concentrate must be diluted prior to infusion, and the diluted solution should be administered through an in-line filter with a microporous membrane not greater than 0.22 microns. Contact of the undiluted concentrate with plasticized polyvinyl chloride (PVC) equipment or devices used to prepare solutions for infusion is not recommended. Diluted paclitaxel solutions should be stored in bottles (glass, polypropylene) or plastic bags (polypropylene, polyolefin) and administered through polyethylene-lined administration sets.

Cladribine (Leustatin-Ortho Biotech), also known as 2-chlorodeoxyadenosine or 2-CdA, is a chlorinated purine nucleoside analog that is structurally similar to fludarabine (Fludara) and pentostatin (Nipent). Although these three purine analogs share certain features, their mechanisms of action and certain of their properties are quite different.

Cladribine is indicated for the treatment of active hairy cell leukemia, as defined by clinically significant anemia, neutropenia, thrombocytopenia, or disease-related symptoms. The new drug represents an important addition to the small group of agents (i.e., interferon alfa-2a [Roferon-A], interferon alfa-2b [Intron A], and pentostatin) that are used in the treatment of this disorder. Cladribine crosses lymphocyte cell membranes and is metabolized to a triphosphate derivative that disrupts cell metabolism and is cytotoxic to both actively dividing and resting cells. Most antineoplastic drugs are active primarily against dividing cells, and the resting cells that escape the action of the drug may be responsible for relapses of the disorder. Because cladribine is cytotoxic against resting as well as dividing lymphocytes, it offers the hope of being more effective than previously available therapies, and some have recommended that it be the drug of choice for patients with hairy cell leukemia that requires treatment.

Although comparative data are very limited, cladribine appears to be at least as effective, and possibly more effective, than the other agents for the treatment of hairy cell leukemia. In addition, the new agent has the advantage of being administered as a single seven-day course of therapy, whereas alpha interferon and pentostatin are administered over longer periods of time and/or as repeated courses of therapy. The single course of treatment with cladribine, in addition to being more convenient, may reduce the risk of adverse reactions.

The most serious adverse reaction associated with the use of cladribine is myelosuppression, which was frequently observed during the first month after starting treatment. Periodic assessment of peripheral blood counts, particularly during the first four to eight weeks, is recommended to detect the development of neutropenia, anemia, and thrombocytopenia, and for early detection of potential sequelae such as infection or bleeding.

In one investigational study in which high doses (four to nine times those recommended for hairy cell leukemia) of cladribine were used as part of a bone marrow transplant conditioning regimen (which also included cyclophosphamide [Cytoxan] and total body irradiation), acute nephrotoxicity and severe, irreversible, neurologic toxicity (paraparesis/quadriparesis) have been reported. However, there have not been any reports of similar reactions with the use of the treatment regimen recommended for hairy cell leukemia.

Cladribine is administered as a single course of treatment by continuous intravenous infusion for seven consecutive days at a dose of 0.09 mg/kg/day. The drug is supplied in single-use vials containing 10 mg (1 mg/ml), and this solution must be diluted with the designated diluent prior to administration. Daily doses are infused continuously over 24 hours, and this procedure should be repeated daily for a total of seven consecutive days. Cladribine has also been prepared as a seven-day infusion which facilitates use with an infusion pump in ambulatory patients.

Agent for ocular disorders

Lodoxamide tromethamine (Alomide-Alcon) is a mast cell stabilizer that is indicated for the topical treatment of the ocular disorders vernal keratoconjunctivitis, vernal conjunctivitis, and vernal keratitis. Vernal keratoconjunctivitis is a noninfectious allergic conjunctivitis involving the cornea and conjunctiva that is characterized by intermittent exacerbations that are often seasonal. The condition is most often experienced by children and young adults, and may be triggered in susceptible individuals by common airborne allergens or contact lenses.

Antihistamines and corticosteroids have been used in the treatment of vernal keratoconjunctivitis, but they have been only partially or temporarily effective in some patients. An ophthalmic solution formulation of the mast cell stabilizer, cromolyn (Opticrom), was effective and widely prescribed. However, this formulation has not been available since 1990 because of manufacturing problems. Since that time, some pharmacists have extemporaneously compounded ophthalmic solutions of cromolyn. With the marketing of lodoxamide, a commercially prepared ophthalmic solution formulation of a mast cell stabilizer is once again available. It is anticipated that an ophthalmic solution of cromolyn will be marketed again once the manufacturing problems are resolved and that an ophthalmic formulation of nedocromil, an analog of cromolyn, will be approved for marketing.

By stabilizing mast cells, lodoxamide prevents the release of histamine and other mediators of an allergic response (e.g., slow-reacting substances of anaphylaxis [SRS-A]). The drug has no intrinsic antihistaminic, vasoconstrictor, cyclooxygenase inhibition, or other anti-inflammatory activity. The new drug is at least as effective as cromolyn in alleviating the symptoms of vernal conjunctivitis and, in one comparative study, lodoxamide was reported to be more effective.

The ophthalmic solution formulation contains lodoxamide tromethamine in a concentration equivalent to 1 mg of lodoxamide per ml (0.1 percent). The recommended dosage for adults and children greater than two years of age is one to two drops in each affected eye four times daily for up to three months.

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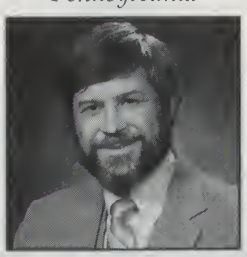

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Asking for Your Help in Maternal and Child Health

Amy K. Dugan
Director of Media Relations
Pennsylvania Medical Society

In a perfect world, every pregnant woman and every child would have access to medical care. Well, it's not a perfect world. Some would argue the problem is access, and some would argue the problem is not taking advantage of the access. Let's put those arguments aside and consider taking advantage of a new program being offered through the state Department of Health which will help us work toward that perfect world. The program is called Maternal and Child Health Outreach, and you can help the program achieve its goal—our goal—healthy babies, healthy moms, and healthy kids.

What's this all about?

The Maternal and Child Health Outreach Program is not a new assistance or reimbursement program; it is a referral network that helps pregnant women and young children take advantage of existing programs to receive prenatal and primary care. The basis of the program is a toll-free help line which pregnant women and parents can call for information on where to get checkups. And to get the word out about this help service, 23 commercials targeting different segments of the population are running on television and radio stations across the state, asking the audience to "Love 'Em with a Checkup."

When people call (800-986-BABY for pregnant women, and 800-986-KIDS for families with children), eight counselors with backgrounds in education, social work, or psychology provide information not only about where to get prenatal or well-baby/kid checkups, but advice on how to pay for them. They answer 50 to 200 calls a day, and to date, more than 20,000 calls have come into the help line. After the initial call, if the caller agrees, the counselor will make a follow-up call to see if the woman or parent was able to make and keep the appointment—and if so, how the appointment went.

How does this affect me?

You can become part of the growing group of doctors, hospitals, and clinics which have agreed to be part of this program. By agreeing, your name is added to the data bank, with any restrictions that you have requested. If a pregnant woman or parent of a young child calls the help line and needs a checkup, and you fit the match, your name may be given as a physician in the area who would see this patient.

The counselors give callers several provider options when available. They also alert callers to the possibility that a provider may not be accepting new patients, and, if that's the case, the counselors are available to help them come up with other options. Remember, this is just a referral program.

The staff from the Maternal and Child Health Outreach Program tell us the ideal provider participants are physicians who accept Medical Assistance patients, especially those who have a presumptive eligibility program or who will accept a sliding fee scale. Currently, those who will provide pediatric care are the most needed, and there are several areas of the state—the northeast, Centre, Westmoreland, Adams, and other more rural counties—where they could use some help.

The current data base contains the names of providers who participate in other state programs. To initiate the program, health department staff contacted approximately 1,000 providers, with whom they had some sort of relationship, to request their participation. Right now, the data base mostly consists of hospitals, but the program has asked the State Society and statewide specialty societies to send a "sign up sheet" to their members in hopes of increasing the data base.

What do I need to do?

If you would like to participate in this referral network, request a Provider Information Survey from the State Society by filling out the coupon on the next page and returning it to the Society at the fax number or address indicated. *When you receive the information form, it is important to note that if you have restrictions on who you will see, there are several places on the form where these can be listed.*

The staff at the Maternal and Child Health Outreach Program have also agreed that you may call them at anytime to change the information in your entry. Call (717) 772-2762, and ask for Program Coordinator Sharon Niesley.

What do the counselors have to say?

The program's telephone counselors are dedicated to this program, committed to helping the most medically needy, and knowledgeable about the system. According to the counselors, about 50 percent of the callers are eligible for Medical Assistance, and a growing number are eligible for the Children's Health Insurance Program (CHIP), since the income and the age eligibility were recently lowered.

Asked their biggest frustration, the counselors agreed: The few times when they've had to tell callers there were no resources in the data bank available to them. One said it was particularly frightening when a caller had an acute problem, and the counselors had difficulty locating a provider who would see her.

Their greatest satisfaction? The family who called April 18 with a daughter with a bladder infection. The girl had a history of bladder problems and kidney infections. The girl's CHIP coverage would kick-in on May 1, but that didn't help a very sick little girl on April 18. A check in the data bank revealed a provider, who gave her the care she needed and was willing to arrange a payment schedule for her.

Or the caller who had a nine-year old who had gotten a spinal infection while in a suburban hospital. Now the mother was pregnant again, and that same hospital was given as a resource for prenatal care. Needless to say, the mother was skeptical of the hospital. The woman needed prenatal care; she had a history of depression and was taking anti-depressant drugs, despite her pregnancy. It took three follow-up calls, but finally the woman went to the hospital for care. And she was completely pleased with the care she received.

Or the report from Polyclinic Hospital in Harrisburg, one of the referral clinics, that it could tell right away when the "Love 'Em with a Checkup" ads air, because their prenatal clinic is busier than ever.

The counselors pride themselves on their holistic approach—being an information referral network and an advocate for these women and children. When asked what results they hope to generate from this "sign-up drive" in PENNSYLVANIA MEDICINE, they said "Any little bit helps."

What does the State Society think?

The State Society supports this referral program and made a commitment to the Department of Health to get this information to members for their consideration. At the kick-off of the help line during an October 1993 press conference at the governor's residence in Harrisburg, then Society President Donald G. Ferguson, MD, thanked those in the crowded room "for working with us to accomplish something that has been a priority of the physicians for many years—getting more pregnant women and children into our offices for care which will give them a healthy start to life!"

Dr. Ferguson also recognized the announcement by the state that in spring 1994 it would begin using the same insurance reimbursement form for Medicaid patients that all other insurers have been using. The State Society had been working toward this initiative for a long time, and the state had agreed to institute it as a way of interesting physicians in taking part in the "Love 'Em with a Checkup" program.

"This will be a tremendous step forward in battling the paperwork crisis that faces today's doctor," Dr. Ferguson said. "And less paperwork gives us more time to do what's most important to all physicians—and that is taking care of people."

Direct any questions about the program to Sharon Niesley at the Department of Health, (717) 722-2762.

Love 'Em with a Check-up
FAX-BACK RESPONSE

Please send me a Program Provider Information Survey so I may lend my name to the Maternal and Child Health Outreach referral network and to the effort to ensure "healthy babies, healthy moms, and healthy kids" in Pennsylvania.

Name _____

Address _____

City _____ State _____ ZIP Code _____

Phone: _____ Fax: _____

FAX this coupon to: Division of Communications and Public Affairs
Pennsylvania Medical Society
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Reaching Out to the Poor

Maureen Hoepfer

Michael A. Moclock, MD, is a board certified family physician who practices part time at the Scranton Primary Health Care Center. He, along with Manuel Fonseca, DO, and Stephen Pascucci, MD, share responsibility for the center's pediatric clinic. The Scranton Primary Health Care Center offers the region's Medical Assistance and indigent populations a full array of medical services, including family medicine, internal medicine, pediatrics, gynecology, and prenatal care. Last year, 6,800 people used the center's services.

Michael Moclock, MD, sees medical practice not as a job or profession, but as a mission. "I look at being a primary care physician as being on a mission, an impossible mission sometimes, but a mission nonetheless," he explains. "Physicians can influence people in changing or modifying unhealthy behaviors. We really can make a difference in their lives."

At the Scranton Primary Health Care Center, Dr. Moclock says he hopes to make an impact on the lives of the children he sees, through educating parents. "To effect a change in behavior, education is extremely important," he says. "I try to sit down with parents and discuss problems or treatments at every visit. I find that parents have many misconceptions about common children's illnesses, and that's why they fail to have their child immunized or follow the prescribed treatment regimen."

Varied patient population

Dr. Moclock says the center takes care of any person who comes in, and the patient population has included a wide range of nationalities: South Vietnamese, Laotians, Cambodians, Mexicans, Haitians, Hispanics, and Soviet Jews. The center also serves the area's large population of migrant workers who pick tomatoes and beans on local farms. "Both the medical care and the housing offered the poor in this region are excellent. We have people coming here from Florida, Mississippi, California, you name it, because the area is well known for its ability to fill your belly, put a roof over your head, and cure your ills," he explains.

Since it opened in 1978, the center has treated thousands of children each year in its pediatric clinic. In 1993, for example, 2,000 children received treatment by the center's physicians. Dr. Moclock says he sees primarily children covered under the Medical Assistance (MA) program or who have no insurance.

Every child who enters the clinic is eligible for the state's Early Periodic Screening Diagnosis Treatment program. The comprehensive program focuses on prevention by screening children in a number of different areas, such as nutrition, dental care, developmental progress, vision, and immunizations. Last October, the center hired a nurse practitioner to oversee the program.

"The screenings allow us to detect problems or potential problems with the children, treat the problem or refer them to specialists if needed, and then keep track of their progress," Dr. Moclock says. "I think we really cover all the bases and do a good job here. The children get good coverage—that's if they come. Because we have such a large transient population, it makes follow-up difficult at times."

Dr. Moclock

Local support

With the help of a grant from the Lackawanna County Medical Society, the Scranton Primary Health Care Center was able to expand its pediatric services from part time to full time in 1992. The pediatric clinic is

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

open Monday through Friday from 9:00 a.m. to 5:00 p.m., with Dr. Moclock and Manuel Fonseca, DO, alternating weeks as the full-time physician on staff. Two mornings each week, Stephen Pascucci, MD, a local pediatrician, also sees patients at the clinic.

In the evenings and on weekends, the center has a coverage agreement with local primary care physicians who admit the center's patients to the hospital if necessary. "The physicians in the area have taken on the responsibility of caring for our patients in the off-hours, and they're doing a good job of it," Dr. Moclock says. "There is never a time when these kids aren't covered."

The beginnings

Dr. Moclock says the Scranton Primary Care Center became a reality because of Martha McAndrew, the center's executive director, and Frances Hazucha, RN, now deceased. The two area women saw a need for a community clinic in 1975 and were instrumental in creating a community task force to examine the problem of caring for the MA and indigent populations in Lackawanna County. The task force was composed of local physicians, nurses, hospital administrators, and community leaders. Representatives from the Lackawanna County Medical Society also served on the task force from the beginning.

The center opened its doors in 1978 after gathering financial support from a variety of organizations, including church groups, the United Way, and the Scranton Area Foundation. It then branched out and was able to secure national grants from the Robert Wood Johnson Foundation, the Kresge Foundation, and the National Campaign for Human Development. Since that time, the center has qualified for Public Health Service grants. It is now a nonprofit corporation governed by a board of directors which meets monthly.

In the beginning, the center's medical staff included two internists and a part-time pediatrician. Since then, it has added a full-time gynecologist and a nurse practitioner. Part-time staff includes a pediatrician, two family physicians, and two social workers. Besides the adult, pediatric, gynecologic, and prenatal clinics, the center also offers complete laboratory testing, a walk-in teenage clinic where adolescents can receive help for medical and psychosocial problems, and an immunization program. For the past three years, the center has sponsored a flu shot program for the elderly in the early fall. Last October, McAndrew says, 700 older persons received flu shots through this program.

With all these services, she says the patients are charged for treatment according to their ability to pay. She explains that the center accepts MA reimbursement, offers free care to the unemployed under a program sponsored by the United Way, and charges other low-income patients on a sliding scale based on the federal poverty guidelines. "No one is ever turned away because of their financial situation," McAndrew says.

Sharing the burden

Dr. Moclock believes the Scranton Primary Health Care Center is a valuable resource for the children in Lackawanna County, but says many other children in the state are not so lucky. "Children make up the biggest population of those living in poverty in the United States," he says. "Many of them suffer unnecessarily because they fail to receive needed medical care."

He says the public does not realize how much free care physicians give to the poor each year, but he believes physicians can do more. "Unfortunately, the reimbursement from Medicaid isn't good, and a practice can go bankrupt from treating a large number of MA and uninsured patients. But I think most practices can absorb treating a small percentage of these patients—say three to five percent." He adds, "If every primary care physician and specialist would agree to care for a small percentage of indigent patients on a regular basis, it would spread out the burden of caring for these patients, and the access problem would ease up."

According to Dr. Moclock, his work at the center has been a worthwhile experience: "It's been satisfying because every now and then I get through to parents and changes will occur that will make a difference in their child's life." He says, "As physicians, our primary goal should not be so much to treat problems as they arise, but to prevent them from happening. There are times when we can do that through educating the patient. Every time we get a chance to talk to our patients about unhealthy behaviors—smoking, poor nutrition, lack of exercise, unsafe sexual practices—we have to do it, because the problems aren't going to go away. There are six billion people on earth, and it's projected to double in the next 40 years. That gives physicians a lot of opportunity to try to change things for the better."

"[Dr. Moclock] says ... the public does not realize how much free care physicians give to the poor each year, but he believes physicians can do more."

Evaluating Ambulatory Care Quality—A Dilemma

John A. Malcolm Jr., MD

One Society member involved in Pennsylvania's data-collection process outlines physician considerations of measuring ambulatory health care quality. This article was prepared for the Pennsylvania Health Care Cost Containment Council as it began its spring discussions, and is offered here by the Society's Task Force on Health Care Cost and Quality Data.

While the overall health of U.S. citizens is strongly dependent on individual lifestyle and informed self-health responsibility, it is also greatly impacted by the access to, use of, and quality of health care at the ambulatory care level. But how can the quality of care in this setting be accurately and efficiently measured?

Because the majority of primary, and much specialty, health care is delivered in the ambulatory setting, appropriate use of care in this setting reduces total health care costs. Early effective treatment of illness often significantly diminishes chances of complications and chronic illness, and preventive care reduces the risk of many serious diseases.

Yet, as the need for ambulatory care services go up, so do the costs for these services. Advances in medical technology have permitted many diagnostic and therapeutic procedures previously done in the hospital setting to be done just as effectively, efficiently, and appropriately in the ambulatory health care setting—often with less cost and inconvenience to the patient. However, because of the continuing shift of more health care to the ambulatory care setting—as well as other factors such as the increasing average age of the population, a growing population, continuing liability-driven defensive medicine practices, and the cost of new sophisticated technology—the overall costs of ambulatory health care are increasing at a rate greater than the general rate of inflation.

Resource utilization review and quality care improvement in ambulatory care have long been a part of physician education; but these are mostly focused on a clinic-type setting in a teaching hospital or medical center. These quality improvement programs focus primarily on improving the *process* of ambulatory health care delivery and require knowledgeable, medically trained staff to abstract and analyze the interrelated financial, delivery process, and medical record data.

Unfortunately, this type of process-focused health care quality improvement program often does not lend itself to use of publishable generic quality measurement data, although some disease-focused reviews do use protocols requiring specific repetitive measurements.

The dilemma

The dilemma is this: How can appropriate, publishable, meaningful data be adapted to measure ambulatory health care quality?

Some disease-focused and some process-focused ambulatory health care quality measurement data can theoretically be gathered, but timely publication becomes a problem because such data are often gathered over an extended period of time with variable intervals between health care delivery visits. While there are no current quality evaluation programs for ambulatory care that publish severity-adjusted comparative reports on cost and quality in the public arena, assessment programs do exist that are disease-specific, include severity of illness evaluation in determining some treatment decisions, and monitor for morbidity during the treatment period.

The difficulty lies in adapting such systems to provide appropriate publishable data with significant meaning. In addition, such an adapted system should not unduly burden health care providers by

Dr. Malcolm, a Sunbury pathologist, is physician representative, Pennsylvania Health Care Cost Containment Council.

requiring substantial additional time, effort, and costs, while providing relatively little benefit over currently used systems. A quick look at a typical process- and disease-focused outpatient quality-of-care assessment methodology may be of some value in understanding the complexity of the problem.

For example, let's consider the comparative process- and disease-focused quality-of-care and severity measurements used in evaluation of outpatient treatment of hypertension (high blood pressure and its sequelae). The process is abbreviated for purposes of simplified illustration and outlined (below) in the series of sequential steps performed. The patient's health care must meet defined quality care standards in each step.

The ultimate goals in such methodologies are improvement in the process and quality of health care delivery, as well as improvement in the outcomes of care. However, a number of related issues must also be addressed.

Currently, outpatient ambulatory care quality assurance programs are required only in licensed health care facilities and organizations such as hospital outpatient clinics, ambulatory surgery facilities, HMOs, etc. The quality assurance/improvement systems and methodologies used to evaluate and improve outpatient care vary widely—hence, comparability of data is a major problem.

If the Pennsylvania Health Care Cost Containment Council wishes to publish outpatient cost and quality-of-care data, both major problems of non-uniform data and limited data sources must be addressed.

Physicians hope that, whatever data is eventually collected and published, it will be reviewed and analyzed by health care professionals, include meaningful outcome statistics, and not unduly burden the health care providers. ⬡

"The dilemma is this: How can appropriate, publishable, meaningful data be adapted to measure ambulatory health care quality?"

An Example

Evaluating Outpatient Treatment of Hypertension

Key

Δ Step includes disease-specific quality-of-care standards to be met.

□ Step includes severity of disease indicators.

O Step may include disease-specific treatment decision factors.

* Step may include disease-specific, patient-specific, and/or treatment-specific morbidity indicators.

Steps performed

Δ□O*—History, physician examination, and office diagnostic testing support the diagnosis of hypertension.

Δ□O*—Initial physician examination and office diagnostic tests include: blood pressure determinations, retinal examination, cardiac auscultation, urinalysis, etc.

ΔO*—Diagnostic workup includes appropriate testing for etiology of the patient's hypertension.

ΔO—Appropriate initial treatment and initial disposition of the patient are made.

ΔO—Appropriate anti-hypertensive, etiologically based treatment is continued, and medications are reviewed regularly until stabilization into normotensive ranges is effected.

Δ□O—Appropriate blood pressure monitoring is performed in the office during initial treatment period until stabilization into normotensive ranges is effected.

ΔO*—Appropriate monitoring for complications and sequelae of hypertension is maintained.

Δ—Appropriate frequency of blood pressure monitoring is maintained after stabilization of the blood pressure into normotensive ranges is effected.

Δ—Appropriate monitoring of medications is maintained after stabilization of the blood pressure into normotensive ranges is effected.

Disposing of Pennsylvania's Low-Level Radioactive Waste

Cherie R. Blazer

Across the country, states face a mounting problem: What to do with the low-level radioactive waste generated within their borders? This article overviews Pennsylvania's recent efforts to answer that question while protecting its residents.

Low-level radioactive waste (LLRW) is the by-product of processes that benefit all of us: the generation of electricity at nuclear power plants, the diagnostic and therapeutic medical procedures performed at our hospitals, and the research at our universities. It is also produced in various industrial applications, such as the development of new drugs by pharmaceutical companies. Despite the obvious benefits we enjoy from these technologies, disposing of this waste presents difficulties in a society that is increasingly adopting a "not-in-my-backyard" sentiment. However, the task has become not whether, but where, to build the disposal facility in Pennsylvania.

Federal legislation has directed each state to take responsibility for its own waste, and to build or obtain access to a LLRW disposal facility. The facilities that have been accepting the waste up to this point are either slated for closure or may no longer accept out-of-region waste.

Low-level radioactive waste is a fact of modern life. It is Pennsylvania's responsibility to find the safest means of disposal for the LLRW our state generates. To fulfill this responsibility, the commonwealth, in an open, public process, contracted the South Carolina-based company, Chem-Nuclear Systems, Inc., to site, design, construct, operate, and eventually close Pennsylvania's LLRW disposal facility. Chem-Nuclear has 23 years of experience operating the largest LLRW disposal facility in the country, located in Barnwell County, South Carolina.

Ms. Blazer is public information specialist, Chem-Nuclear Systems, Inc., Harrisburg.

Why Pennsylvania?

The federal legislation that directed each state to take responsibility for its own waste also encouraged states to form compacts—groups of states which agree to share a regional facility. By forming compacts, states can exclude out-of-compact waste. In response, Pennsylvania, Delaware, West Virginia, and Maryland formed the Appalachian States Compact (see Figure One, next page). Pennsylvania, as the largest generator of LLRW within its compact, will be hosting the facility.

What is LLRW?

LLRW includes items—protective clothing, machinery, lab equipment, and filters and resins—that have been contaminated with radioactive materials. It is also defined by what it is not: It is *not* spent nuclear fuel and fuel rods from nuclear power plants and weapons production. Disposal of these high-level, long-lived wastes is the responsibility of the federal government. Because LLRW is defined in federal and state law, strict regulations prevent disposal of anything else at the Pennsylvania facility.

There are three classifications of LLRW:

- *Class A* waste is the least radioactive, and decays to background or safe levels—equal to or less than the levels of radioactivity normally found in the soil outside a home—in 100 years. It consists largely of protective clothing and similar materials.
- *Class B* waste decays within 300 years and typically includes filters and resins for cleaning contaminated water.
- The highest-activity material disposed of in the facility, *Class C* waste, decays to safe levels within 500 years and includes the metal equipment that has become radioactive during use in a nuclear reactor.

The disposal process

Pennsylvania's LLRW disposal system will be built above the existing ground surface and will use "triple safe" technology, a combination of man-made and natural barriers designed to contain and isolate the waste. Waste will arrive at the facility on trucks in closed transport containers that meet U.S. Department of Transportation or U.S. Nuclear Regulatory Commis-

sion specifications. The waste will be placed inside concrete *overpacks,* sealed with concrete to form a solid structure (see Figure Two, page 28).

The concrete overpacks are then placed in large, thick-walled concrete *cells* that are box-shaped and include four sides, a top, and a floor. Each cell has its own monitoring system. Further protection is provided by an *earthen cap* composed of sand, clay and soils, a polyethylene cover, and topsoil (see Figure Three, page 28). This is a closed system. The only way radioactive materials could escape from this facility is by prolonged contact with water, and the facility is carefully designed to keep water out.

In the past, LLRW was often buried underground, in metal drums or cardboard containers. Problems arose when liquid wastes escaped or water came in contact with the waste, causing radioactive elements to leach into the ground. For these reasons, only dry, solid wastes are accepted at LLRW facilities; no liquid wastes will be disposed at the Pennsylvania facility.

Health and safety

After 30 years of operation, the Pennsylvania LLRW disposal facility is to be turned over to a state custodial agency to provide monitoring and maintenance. Pennsylvania's Low-Level Radioactive Waste Disposal Act (Act 12 of 1988) requires that a long-term care fund be established from surcharges on LLRW disposed of at the facility and provides for a separate $100 million liability fund to protect the host municipality, the county, and the commonwealth.

Act 12 also provides for funding to hire two full-time independent inspectors by the municipality, and two more by the county, who will inspect the facility and have legal authority to shut it down if it is not operating according to specifications. Local police, fire, and ambulance personnel will receive special training and support. Chem-Nuclear will also provide health monitoring for residents living within five miles of the facility during operations.

Although the facility will only operate for 30 years, Chem-Nuclear promises to meet or exceed the safety requirements that have been set out in law. The Pennsylvania LLRW Disposal Act specifies that the design goal of the facility is "zero release" of any harmful materials. This means no negative health effects.

The siting process

The siting process underway in Pennsylvania is among the most stringent in the nation regarding LLRW disposal. As the state is screened for potentially suitable sites, specific criteria—based in law and regulation, and developed with significant public input—are applied to the land areas of the entire commonwealth. These "disqualification" criteria indicate where a facility cannot go—for example, in areas of mines, limestone, or within wildlife or protected area boundaries.

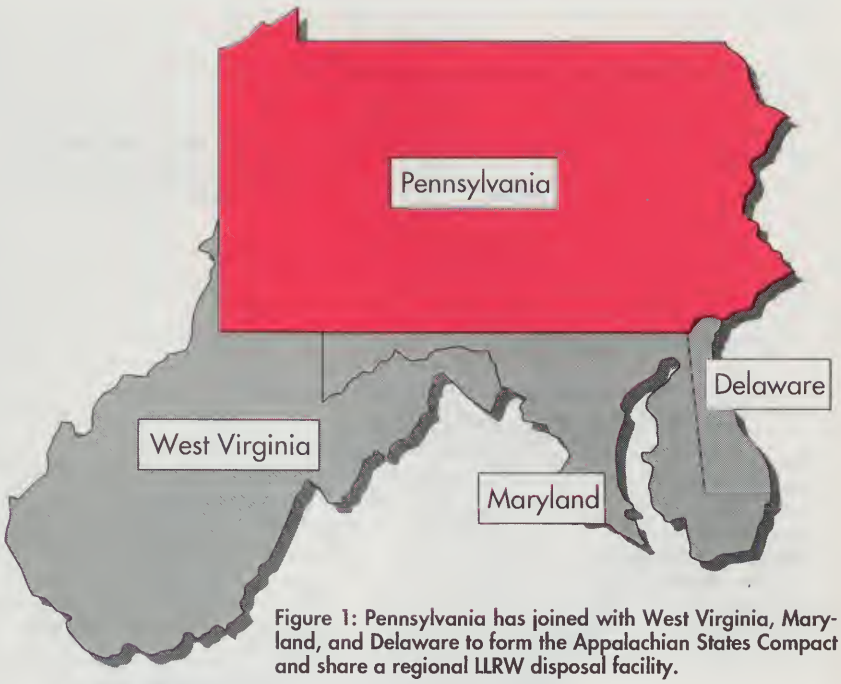


Figure 1: Pennsylvania has joined with West Virginia, Maryland, and Delaware to form the Appalachian States Compact and share a regional LLRW disposal facility.

Disqualification is accomplished in three stages: statewide, regional, and local. At each stage the scale of the maps used to identify disqualified areas becomes more detailed, and particular criteria become visible. The information used to disqualify areas is gathered from publicly available sources, and in cooperation with state and federal agencies. The data are compiled using a highly technical, computer-based geographic information system. At the end of each stage, Chem-Nuclear produces a composite map showing the land areas in the state that have been disqualified from further siting consideration.

After the disqualification process is complete, *evaluation* screening begins, in which both technical criteria and public values are applied to the areas remaining under consideration to identify those most suitable for siting. The results of a random, mailed survey are considered during evaluation. This survey is a crucial element of the process, which allows Chem-Nuclear to determine what factors the public feels are more important when locating a site. →

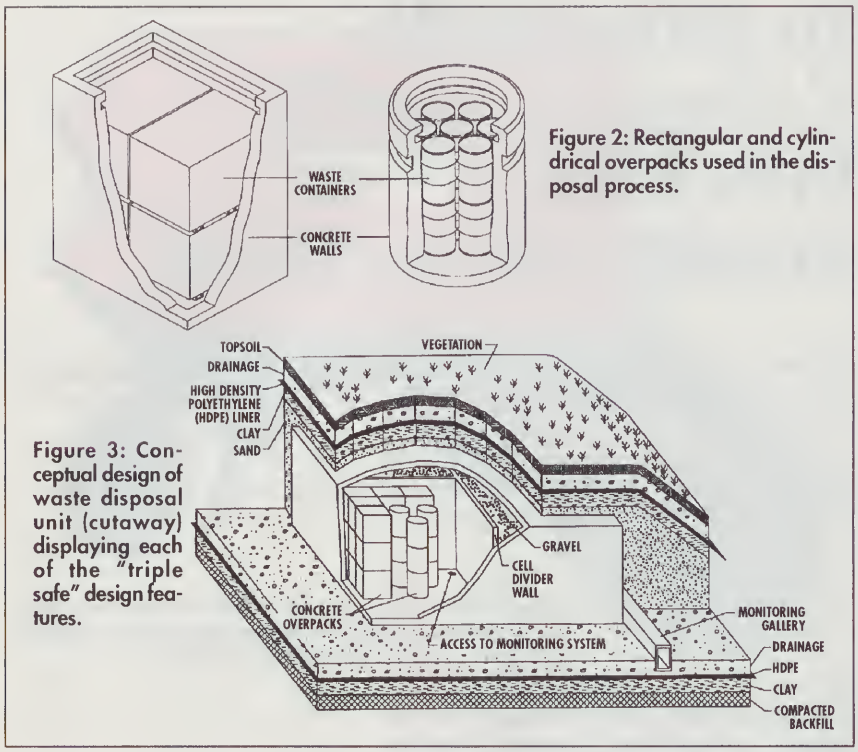


Figure 2: Rectangular and cylindrical overpacks used in the disposal process.

Figure 3: Conceptual design of waste disposal unit (cutaway) displaying each of the "triple safe" design features.

Spokespersons Sought on Radioactive Waste Disposal

Organizations United for Responsible Low-Level Radioactive Waste Solutions is seeking physicians in 11 states, including Pennsylvania, willing to speak to increase awareness and support for the beneficial uses of radioactive materials and the need for responsible solutions for the disposal of these materials.

The goal of the national coalition is to achieve progress on building new waste disposal facilities and preserving the benefits of nuclear technology. Members include the American Medical Association, the American College of Nuclear Physicians, the Health Physics Society, the American Society of Nuclear Cardiology, the Association of American Medical Colleges, and the Society for Nuclear Medicine.

Organizations United will provide necessary training to interested physicians. For more information, call James M. Lyznicki in the AMA's Department of Preventive Medicine and Public Health at (312) 464-4520.

Not until after the evaluation process is complete will three potentially suitable sites of approximately 500 acres each be named. These three sites are then submitted for review to the Pennsylvania Environmental Quality Board (EQB). Upon EQB approval, detailed characterization—on-site inspection and testing—of each of the three sites will aid Chem-Nuclear in identifying a single site for the LLRW disposal facility. The company will then apply to the Department of Environmental Resources (DER) for a license to build the facility. DER is the regulator and contract administrator for this contract.

Pennsylvania law requires Chem-Nuclear to consider, in the siting process, volunteers that may come forward to host this facility. A volunteer site must be brought forward by the governing body of a municipality. Private landowners may not volunteer their property, but are encouraged to contact Chem-Nuclear for information about the project to share with their local elected officials and community. Volunteer municipalities are subject to the same strict siting criteria used to examine the entire state and may not be considered until the process of disqualification is complete.

Project status

Chem-Nuclear completed Stage One and released statewide screening maps in November of 1991. These maps identified 23 percent of the state as disqualified from further siting consideration for Pennsylvania's LLRW disposal facility. Stage Two work was completed in February of 1993, and regional maps showed an additional 23 percent of the state disqualified, for a total of 46 percent.

After the completion of each stage, public meetings were held across the commonwealth to share the results with citizens. These public meetings included project presentations, question-and-answer-sessions, and the opportunity to view the composite maps. The Stage Two public meetings also included interactive workshops, which provided detail on the disqualification and evaluation processes, and gave citizens the opportunity to speak directly with the people doing the work.

At a press conference held May 17 by DER, Chem-Nuclear released the Stage Three (local) disqualification maps, which show approximately 75 percent of the state disqualified from further siting considerations. Throughout May and June, the company held public meetings in Harrisburg, Erie, Altoona, Coraopolis, Williamsport, Wilkes-Barre, and Valley Forge. These meetings provided Pennsylvanians the opportunity to find out about the project, provide feedback to the process, ask questions of the staff members actually doing the siting work, and view the detailed disqualification maps.

Public involvement

Chem-Nuclear's goal throughout the facility development process is to keep Pennsylvanians informed of and involved in project activities. This project places a strong emphasis on citizen involvement, because a knowledgeable public is in the best position to make sound judgments regarding this issue. Chem-Nuclear operates a toll-free information line (800-424-2848) to answer citizens' questions.

In addition to the public meetings held after each stage of siting, the company implements a very active speakers' bureau program and has provided presentations to groups across the state that include local government entities such as county commissioners, township supervisors, and planners; environmental groups; business and industry; community groups such as Lions, Kiwanis, Rotary, church organizations; and educators.

For more information about this issue, call Chem-Nuclear at (800) 424-2848.

SOCIETY TESTIMONY ADDRESSES CON CONCERNS

Richard D. Baltz, MD, a Harrisburg pediatrician and chairman of the State Society's Interspecialty Section, testified in May before the Pennsylvania Department of Health on the proposed Surgical Services Chapter of the State Health Services Plan—a product of the 1992 revision of Pennsylvania's certificate of need (CON) law.

The state's original CON law, enacted in 1979 to help control health care costs by regulating capital construction and minimizing duplication of medical services, required health care facilities to obtain state approval before undertaking major capital projects or introducing new services. The 1992 revision changed the focus of review to clinically related health services.

Under the 1992 law, CON applicants must demonstrate that their plans are consistent with the requirements of the State Health Services Plan, which outlines the degree to which certain services are needed in each region of the state and sets specific criteria for reviewing CON projects. The Surgical Services Chapter is just one of several chapters under consideration by the commonwealth's Health Policy Board, which is responsible to adopt a new plan under the new law.

Dr. Baltz, who testified on this same issue last summer, most recently expressed the Society's concerns about the impact of the proposed chapter "on the commonwealth's efforts to address the difficult task of health system reform." He said, "Reform, we all agree, is necessary to ensure access to affordable, quality health care for all Pennsylvanians. This chapter, however, promotes the status quo of the delivery of surgical services in Pennsylvania.

He explained that the proposed Surgical Services Chapter would require that all applications for development of ambulatory surgical facilities (ASFs) pass a "need" test, and that the Department of Health has projected a *surplus* of operating facilities in all but one planning area, and in the remaining area, there is "no need."

"Given the department's projected need—or lack thereof," he said, "it's quite obvious that the proposed guidelines amount to a notice that 'ASFs need not apply.' This is incredibly short-sighted, particularly since 70 percent of the operating rooms (ORs) used to determine operating room capacity in Pennsylvania are combined-use ORs, not ones specifically designated for ambulatory surgery."

He explained that a significant and continuing growth trend exists in ambulatory surgical care today, primarily driven by pressures to contain costs as well as advances in technology: "Nationally, more and more services are moving from inpatient to outpatient settings, [and] as the Surgical Services Chapter is now written, Pennsylvania will meet the growing demand for outpatient surgery primarily with ORs that are used for both inpatient and outpatient surgery (combined-use ORs), which are clearly less efficient and cost effective" than ASFs.

The Society questioned the advisability of including all Pennsylvania combined-use ORs when determining whether there is a need for outpatient surgery ORs. As Dr. Baltz said: "Considering that 70 percent of current OR capacity is combined-use ORs, we believe the department is promoting the status quo in outpatient surgery and not moving Pennsylvania in the direction of more efficient and cost effective surgery." He also questioned why criteria for ambulatory surgical facilities are "clearly more restrictive" than those for hospital-based outpatient surgical services. "The disparity...discriminates against free-standing ambulatory surgical facilities," he said.

Dr. Baltz urged the department to "rethink" the proposed chapter and recommended that the department "use one-quarter of the combined use ORs in determining the projected shortage or surplus of outpatient ORs in Pennsylvania for the year 2000." He explained: "Doing this will result in a shortage of 76 outpatient ORs in Pennsylvania. This is not a huge shortage, but it will give Pennsylvania the ability to provide health care in a more efficient and cost effective manner. It will give us the opportunity to position ourselves for the future."

Finally, he recommended that the supplementary criteria for ambulatory surgical facilities and hospital-based outpatient surgical services be identical.

Press time update

At press time, the State Health Services Plan had been approved by the State Health Policy Board and signed by the governor. Although the Society's recommendations for revising the proposed Surgical Services Chapter were not utilized, the need formula in the chapter was revised, and the use of hospital-based mixed-use or general purpose ORs for projecting future need for outpatient ORs was addressed.

The surplus of outpatient ORs has been reduced substantially, and a shortage of outpatient ORs is indicated in one region of the state. Also, the projections used in the Surgical Services Chapter are only through 1995—instead of through the year 2000, as originally proposed.

The Department of Health has indicated a willingness to work with the Society to revise the chapter in the coming year.

For more information, call the Society's Department of Medical Staff Relations at (800) 228-7823 or (717) 558-7750.

This article includes excerpts from: Zeik M. What physicians need to know: new state CON law. PA MED 96(3):12-14, 1993.

INSTITUTE WARNS OF RISKS OF NITROUS OXIDE EXPOSURE

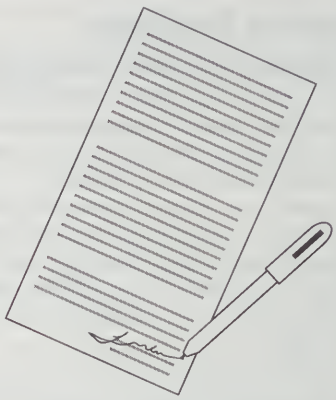
The National Institute for Occupational Safety and Health (NIOSH) has issued a warning to health care workers that exposure to nitrous oxide (N_2O) may cause serious health effects, even with preventive measures such as scavenging systems in place.

Several human studies have shown that occupational exposure to N_2O may cause reduced fertility, spontaneous abortions, and neurologic, renal, and liver disease, as well as documented decreases in mental performance, audiovisual ability, and manual dexterity.

To protect workers from these risks, operating rooms are often equipped with scavenging systems that vent unused and exhaled gas away from the work area. However, a NIOSH alert issued this spring reports that such a system must be continuously monitored to effectively reduce exposure to N_2O.

To request a copy of the alert, call NIOSH at (800) 356-4674.

Before You Sign That Managed Care Contract...



Did you know that contracts from some third-party carriers contain provisions that would impinge on your legal and ethical duties to protect patient confidentiality? Before you sign any contract—and especially one of the many varieties of managed care contracts springing up—read and understand the terms it contains. Consider these items so that you can make an informed decision about what is best for your practice and your patients:

Restrictions on practice

- ☑ Beware of restrictive language that would prohibit you from contracting with additional managed care entities.
- ☑ Be sure the contract gives you the right to reject any new groups of patients or alternate fee arrangements without terminating your right to provide services to existing patients.
- ☑ Beware of the ability of the managed care entity to make unilateral modifications to the contract regarding regulations, compliance, and payments.

Payment terms/fee schedules

- ☑ Negotiate to be sure that the payment amount is adequate—whether you're solo or group, capitation or fee-for-service—before proceeding any further. This will require careful analysis of the economics of your practice.
- ☑ The stated rights of the managed care entity may provide the suspension of reimbursements to providers for a variety of reasons. Know what would or could cause a cessation of payment.
- ☑ Be sure the contract identifies clearly the party or parties responsible for payment, so that you can investigate their financial strength, client base, and reputation.
- ☑ Make sure not only that payment of your fees is required within a specified number of days, but also that there are meaningful incentives for the payer to comply with this rule.
- ☑ Check to see that you are allowed a reasonable time to submit completed bills, and that you're allowed to submit bills after the designated time in circumstances beyond your control.
- ☑ Find out if you can change the fee schedule into real dollars per hour or dollars per procedure.
- ☑ Make sure that, if the contract provides for or contemplates capitation, risk sharing, or withhold arrangements, the descriptions of these are sufficiently clear and detailed to allow you to fully evaluate your risk.
- ☑ If it's a capitated contract, ask yourself if it allows you to increase the amount "per member per month" if the rate of referrals greatly increases.
- ☑ Ask whether you are allowed to bill patients: a) when the managed care organization or the payer fails or is unable to pay, b) for services not covered by the contract, and c) when the payer or managed care organization have determined the proposed services are not medically necessary.

Patient eligibility and care

- ☑ Make sure the managed care organization gives you a detailed, written description of the procedure for verification of patient eligibility and coverage.
- ☑ Read and understand the set of criteria that you must follow, including practice and administrative guidelines. These guidelines are usually established as a required minimum level of performance.
- ☑ Beware of economic penalties for providing treatment outside the realm of established practice guidelines, i.e., if you prescribed a level of care unacceptable to the payer—you pay the patient's bill.
- ☑ Make sure the contract doesn't hold you to a standard of medical practice higher than "a reasonable physician acting under the same or similar circumstances."
- ☑ Make sure that if you're required to provide anything other than medical services—for example, participation in the peer review committee—you have adequate legal protection and reasonable compensation for such activities.
- ☑ Double check if there are any provisions that require you to significantly alter your practice—such as your availability, referral practices, or staffing.

Physician insurance

- ☑ Be cautious about signing a contract that contains an indemnification provision by which you agree to "indemnify" or "hold harmless" the payer. Malpractice insurance policies often exclude liability that the physician assumes as a result of a contract, i.e., a third-party payer.
- ☑ Know whether you're required to obtain more insurance coverage or different types of insurance than your current insurance.
- ☑ Make sure the contract specifies the amount and type of insurance covering the managed care entity's activities, and that you will be covered as an additional insured.

Other clauses and terms

- ☑ Beware of "consent" forms that place an undue reporting requirement on you and/or your staff.

- ☑ Know the credentialing/review process and requirements of the managed care entity.
- ☑ Beware of long-term contracts—three-year to five-year contracts are not unheard of—and be careful of contracts that limit your ability to terminate the contract at will.
- ☑ Look for a definite expiration date, and make sure that neither party can unilaterally amend or cancel the contract—or any related documents such as the fee schedule—prior to that date.
- ☑ Make sure the managed care entity is prohibited from disclosing any information provided by you or about you in connection with any credentialing or peer review deliberations, unless such disclosure is otherwise required by law.
- ☑ Double check that you have received all of the documents which relate to the contract, and all the details about the managed care entity—how long it's been around, it's history, what hospitals and physicians participate, and a list of the primary care physicians.
- ☑ Beware of exaggerated or unclear marketing plans or materials.
- ☑ Triple check that any verbal promises that the managed care entity made to you have been incorporated into the contract.

Portions of this article are reprinted with permission from MSDC NEWSLINE, a publication of the Medical Society of the District of Columbia, April 22, 1994. Additional material is excerpted from Pennsylvania Medical Society publications.

HCFA PROJECT TO EASE MEDICARE PROCESSING

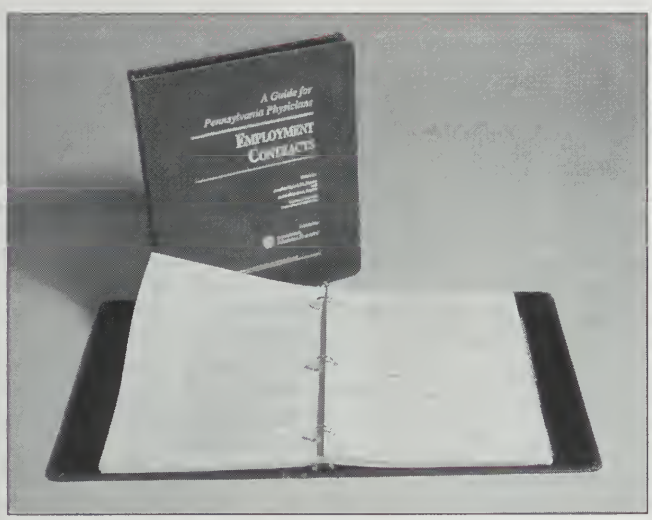
The Health Care Financing Administration (HCFA) has undertaken a six-year, $19 million project that it says will revolutionize the processing of Medicare health claims in the U.S. The project, called the Medicare Transaction System (MTS), will use the most advanced computer technology available to process more than a billion Medicare claims by the year 2000, according to HCFA.

MTS will consolidate in one system the automated claims processing functions currently performed by 79 contractors using 14 claims processing systems to process Medicare claims at 62 sites around the country. HCFA anticipates that legislative and policy changes will be implemented more accurately and reliably, and administrative costs will be cut by as much as $200 million per year.

HCFA adds that the new system will benefit physicians and researchers, as well as beneficiaries:

- The consolidation of claims processing will result in more uniform application of coverage and payment policies, and will make it easier for physicians' offices to connect to Medicare eligibility and other information.
- Better data will be available for researchers studying program trends in health services delivery.
- Beneficiaries can expect improved services from better coordination of benefits and the sharing of information among different insurers, including Medigap carriers.

MTS is currently in the design and development stage. Implementation is expected to begin in 1997, with completion by late 1998. The new system will be government owned, but operated by private companies under contract.



Employment Contracts Guide Offers Timely Advice

Many physicians today are faced with signing employment contracts, either as an employer or an employee. To help physicians make the right contracting decisions, the Pennsylvania Medical Society has published *A Guide for Pennsylvania Physicians: Employment Contracts.*

The 74-page comprehensive manual was designed to assist physicians in understanding, discussing, and negotiating balanced employment contracts with various health care providers. The guide looks at key personal considerations, contracting basics, various contracting arrangements, model contracts, and conflicts of interest. It also reviews and discusses contract language in both employment and independent contractor arrangements.

Employment Contracts is priced at $40 for members and $60 for nonmembers.
To order, call the Society's Department of Physician Services at (800) 228-7823 or (717) 558-7750.

The State Society will also offer a seminar on contracting on October 12 and 13. Look for more details later this summer.

WORKERS' COMPENSATION

FEES DROP, PAPERWORK UP UNDER NEW LAW

Pennsylvania's new workers' compensation law (Act 44 of 1993), enacted exactly one year ago, continues to make headlines throughout the commonwealth. Most recently the *Central Penn Business Journal,* published in Harrisburg, reported that physicians are seeing a decrease in reimbursement and an increase in paperwork as a result of the law.

Doctors are "the main target of the price cap on health care services" in the new law, the journal says, and some have seen compensation go down as much as 30 or 40 percent. Certain specialists—especially orthopedic surgeons and neurosurgeons—have been hardest hit by the reform because of the numbers of workers' comp patients they see.

"Some specialists have decided not to see workers' comp patients at all," the journal reports, "raising questions about whether patients will continue getting adequate access to medical care." Wesley Johnson, executive director of the state House of Representatives Labor Relations Committee, says in the article, "If providers aren't going to treat injured workers, then we've still got a problem."

The new law caps medical provider fees at 113 percent of Medicare allowances. While government officials and insureds say these caps—modeled after similar auto insurance reform of a few years earlier—were necessary to control Pennsylvania's rapidly climbing workers' comp costs, the State Society notes that tying fees to Medicare rates has caused problems, including adding a whole new layer to the reimbursement system.

The Society also notes that problems have arisen from differences in fee schedules and payments from one region to another: "What results is basically an argument between insurer and health care provider over how much the provider should be paid."

In the meantime, family physicians are concerned with bureaucracy issues: The new law requires an injured worker to wait 30 days after an injury before being able to switch from a company-recommended doctor to the family doctor; under the old law, the limit was 14 days. Also, the new law requires that more information be sent from the physician to the employer and the insurance company—thus added paperwork.

This article is excerpted in part with permission from: Cummings E. Doctors say new system is no cure. Central PA Bus J *10(9):1,11, 1994.*

AUTO INSURANCE

SOCIETY SUPPORTING ACT 6 AMENDMENT

The State Society is supporting an amendment to House Bill 2413, which amends Act 6 of 1990, on motor vehicle fiscal responsibility.

The Society has identified a number of problems with the implementation of Act 6, and despite attempts to correct the problems through regulations, many difficulties continue related to the submission of claims for reimbursement for medical services provided under the act. Also, the Society contends that actions of insurers and peer review organizations continue to adversely affect the insured in obtaining needed care and penalize the providers of such care.

The amendment, which introduces standards for the conduct of peer review in evaluating the necessity of care, proposes to:

- prohibit separate contracting between insurers and peer review organizations (PROs);
- require criteria used for PRO evaluation of medical necessity of treatment provided to be openly published;
- prevent PRO evaluations from being used for determination of causation or relatedness;
- require payment of all medical services within 30 days of submission of claim except where necessity of the services provided is challenged;
- limit charges for PRO evaluation to 110 percent of the comparable Medicare consultation/evaluation payment allowance;
- afford all parties all remedies of appeal; and
- require notification of insured of possible limitation of benefits due to determination of medical necessity.

In a letter of support of the amendment to members of the House of Representatives, State Society President Martin A. Murcek, MD, wrote, "The amendment will help to correct the current one-sidedness of portions of the peer review process. It will insure that necessity decisions are based on appropriateness of services and outcome of treatment, and not on the bottom line of coverage limits."

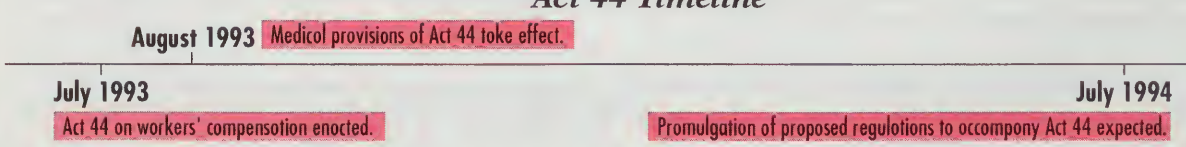
At press time, the bill awaiting House consideration.

Members Urged to Carefully Review Network Contracts

The State Society urges members to carefully review before signing any contracts to join workers' compensation provider networks. The Society warns that while networks may resemble coordinated care organizations (CCOs) authorized under the workers' comp law, they may not be state-approved.

Direct any questions or concerns about this issue to the Society's Department of Regulatory Affairs and Specialty Legislation at (800) 228-7823. Also, see page 34 for more on this topic.

Act 44 Timeline



As the timeline above shows, at press time the State Society was still awaiting promulgation of draft regulations to accompany Pennsylvania's new workers' compensation law. In early 1994, the Society offered the Department of Labor and Industry language on a number of issues related to workers' compensation reform in the commonwealth. We will not know if the department has incorporated any of our suggestions until the draft regulations are released. Look for an update this fall in PENNSYLVANIA MEDICINE.

AMA BOOSTS PATIENT PROTECTION ACT

The American Medical Association (AMA), all 51 state medical societies, and more than 40 national medical specialty societies are supporting the newly introduced Patient Protection Act and its inclusion in any health system reform legislation adopted by the U.S. Congress.

The bipartisan bill, H.R. 4527, was introduced to the House in late May by Representatives Collin Peterson (D-MN) and Wayne Allard (R-CO). Other sponsors include Representatives J. Roy Rowland, MD (D-GA), Ralph Hall (D-TX), and Greg Laughlin (D-TX). Senators Paul Wellstone (D-MN) and Conrad Burns (R-MT) also voiced support of the bill and were expected to introduce it in the Senate at press time.

The Pennsylvania Medical Society—through its Capitol Contacts—in early June urged members of Congress to support the bill which, according to the AMA, "contains four essential elements for guaranteeing freedom of choice and protecting patients from the abusive practices of some insurance companies." Those elements are:

Patient freedom of choice

The Patient Protection Act would require that patients be offered the choice of three insurance options—an HMO or PPO, a traditional insurance plan (with copayments and deductibles), and a benefit payment schedule.

Also, the act would provide patients with an annual opportunity to select a point-of-service option. Available for an added premium, this option provides a patient with insurance coverage even if the patient selects a physician outside of the insurance network or plan.

Disclosure of restrictive insurance policies to patients

Prior to enrollment in an insurance plan, patients would be provided with more complete and easily understandable information about policies that may restrict access to medical services. Insurance companies would be required to describe in simple terms:

- what medical services are covered and included,
- prior authorization or other utilization review requirements,
- financial incentives for health professionals to withhold or limit medical services, and
- restrictions on referrals to medical specialists.

Insurers would be required to disclose the percentage of premium dollars spent on direct patient care services and patient satisfaction data from current and previous enrollees.

Physician selection criteria

Patient freedom to personally select a physician of choice is frequently limited by insurance companies' criteria for network providers.

To expand patient choice of physicians and to protect against arbitrary exclusions of providers, the act would require insurance companies to disclose physician selection criteria. Insurance plans would also be prohibited from terminating a physician contract without cause and would have to provide applicants with all of the reasons for denial of an application or termination of a physician contract. Physicians would also be provided with due process rights for adverse actions by insurers.

Utilization review safeguards

Currently, patients and physicians are kept in the dark regarding insurance company criteria for utilization review and coverage decisions. The act would end this "black box" mentality by requiring advance disclosure of utilization review screening criteria. Medical policies governing coverage and payment would have to be based on sound clinical and scientific data rather than the financial bottom line.

Participating physicians would have a formal mechanism for input on setting insurance plan policies governing credentialing, coverage, quality, and utilization review policies. Patients and physicians would no longer be subject to the hassle of waiting for days to receive prior approval for medically necessary services.

The managed care industry has acknowledged the need to correct the abuses of some insurance plans by establishing a utilization review accreditation process. The act would establish federal standards for utilization review activities and grant deemed status for private sector accreditation programs.

The AMA says these provisions will assure that patients are provided with informed choices in the selection of health insurance coverage and personal physicians. The organization adds that it is critical that all patients be aware of potential limits on their access to medically necessary services as well as the financial obligations attendant to such decisions.

Patient Advocacy Program

The AMA is asking patients to join with physicians in support of the Patient Protection Act. New materials—designed to encourage patients to lobby their senators and representatives to support the act—are available by calling the AMA at (800) 262-3211.

Patient Protection Act Provisions

The Patient Protection Act would entitle patients to:

- A list of covered services—exactly what the plan pays for.
- A list of exclusions—what patients need to pay for themselves.
- Clear instructions on whom to call before a physician can treat them.
- Survey information on how other patients feel about the health plan.
- A choice of three plan options: HMO or PPO, traditional insurance plan, or benefit payment schedule.
- Access to a point-of-service plan—the opportunity to pay extra to see a doctor outside the plan.

To allow physicians to give patients the care they need, the following would also be required of all health plans:

- Plans must allow physicians a voice in medical policy-making.
- No physician could be removed from a plan for giving patients the care they need.
- Practicing physicians would have an essential role in developing criteria to ensure quality patient care.
- Plans would be required to disclose to physicians just who is reviewing their work.

Source: American Medical Association

ACTIONS OF THE BOARD OF TRUSTEES, MAY 11, 1994

LEGAL COUNSEL STUDYING WORKERS' COMP REFORM ACT

Physicians are reporting increasing problems with implementation of the medical provisions of the Workers' Compensation Reform Act (Act 44 of 1993)—problems with reporting of services rendered, documentation of services, and delays and other actions by insurers and others to reduce or deny payments. Since efforts to resolve these problems through appeals mechanisms in the statute have proven unsuccessful, the Society's board authorized legal counsel to investigate and report on other action possible to address the problems.

In a report to the board recommending the investigation, the Society's Council on Governmental Relations says appeals have been unsuccessful "due to the tremendous number of complaints and the lack of definitive regulations to clarify ambiguous and confusing language in the law."

The Society has been in regular contact with the bureau about problems since passage of the law last year, but the council says, "Despite an apparent willingness by the Department of Labor and Industry, Bureau of Workers' Compensation to address these problems, insurers act with disregard to the law."

One of the Society's courses of action is to carefully review the regulations as soon as they are published and seek further corrections through those regulations if possible.

Physicians who have encountered problems with the act, but who have not filed a previous complaint, should write to Don McCoy, the Society's director of regulatory affairs and specialty legislation, at P.O. Box 8820, Harrisburg, PA 17105-8820. Please include a complete description of the nature and results of all problems.

For more on this issue, see "Fees Drop, Paperwork Up Under New Law," page 32.

ROLE IN HEALTHCHOICES LAWSUIT UNCERTAIN

The board will further consider the facts of a lawsuit challenging HealthChoices—a new case management and claims processing system for Medical Assistance (MA) recipients in the Philadelphia area—before making a decision about whether or not to join the suit as amicus curiae ("friend of the court"), as recommended by the Philadelphia County Medical Society.

The Hospital Association of Pennsylvania, the Coalition of High Volume Medical Assistance Hospitals, and the Pennsylvania Health Law Project filed the lawsuit against the Pennsylvania Department of Public Welfare for not having promulgated regulations for HealthChoices. A hearing on the preliminary injunction was held in mid-May; at press time, supplemental briefs were being written.

A decision on the case is expected prior to the July 4 holiday. Look for updates in future issues of PENNSYLVANIA MEDICINE and *Executive Report*.

ALTERNATIVES TO UPPING CAT FUND LIMITS DECLINED

As reported in the May issue of PENNSYLVANIA MEDICINE, the Catastrophe Loss Fund (CAT Fund) is supporting a proposed increase in malpractice insurance limits for primary insurance from $200,000 to $500,000. Total mandated insurance coverage would thus increase from $1.2 million to $1.5 million per occurrence.

Amendment of the Health Care Services Malpractice Act (Act 111 of 1975) is required to increase the limits. At the request of the CAT Fund, the Society reviewed proposed amendments and, having several concerns, offered alternatives for consideration; however, none were accepted. The Society has met with the Hospital Association of Pennsylvania to discuss both organizations' concerns on the issue.

At press time, the Society was urging the fund not to pursue any amendments, citing that the limit changes would cause substantial increases for all physicians from all carriers.

BOARD RETREAT TO FOCUS ON PHYSICIAN INVOLVEMENT

The Board of Trustees will gather in Hershey this month to consider the future structure and direction of the State Society. Topping the agenda is a study of ideas from the Society's Task Force to Enhance Physician Involvement.

Created in 1993 to study physician involvement and membership in the Society, the task force early last fall conducted a series of focus groups which revealed a pressing need to clarify the Society's image to Pennsylvania physicians. A follow-up study, conducted this spring, brought into focus a number of membership perceptions and nonmember needs which the board will begin to address at its July meeting.

A wrap-up of the retreat will be published in the September issue of PENNSYLVANIA MEDICINE. A full report of board actions resulting from the

"We are the voice of the American medical profession. We are the partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of the public health. We serve physicians and their patients by establishing and promoting ethical, educational, and clinical standards for the medical profession and by advocating for the highest principle of all—the integrity of the physician/patient relationship."

New mission statement approved by the AMA Board of Trustees at its April meeting

retreat or future task force meetings will be presented to the House of Delegates at its annual meeting in October.

OTHER ACTIONS OF THE BOARD

In other action at the May meeting, the board:

- approved funds for the Society to jointly sponsor a health care antitrust seminar later this year. The Society will make funds available subject to contributions from the Pennsylvania Bar Association, the Hospital Association of Pennsylvania, and other proposed cosponsors. Although no date has been set, the Society anticipates the seminar—which will focus on antitrust issues related to integrated delivery systems—will be scheduled in the fall. At press time, a coordinating committee was being formed to plan the seminar. Watch for details later this summer.
- adopted a recommendation of the Task Force on Health System Reform and Access that a letter be written to hospital medical staffs, encouraging them to implement the Society's automated physician referral network system or an alternative system that documents the effectiveness of their efforts.

AMA NEWS

ORGANIZED MEDICINE PREPARES TO REINVENT ITSELF

In a landmark meeting, 162 representatives of county, state, and specialty medical associations, as well as the American Medical Association and other related organizations, on May 26 launched a two-year project to reinvent the house of medicine. The Study of the Federation, initiated by the AMA and supported by Federation members, is an examination of the way in which organized medical societies will be configured to define and meet physician needs, and thus help them serve patients into the twenty-first century.

The initial meeting of the project focused around a deliberative body known as the Consortium, configured especially for this project to reflect the diversity of organized medicine in terms of age, gender, race, practice arrangement, specialty, and type of medical association. Participation on the Consortium, which is scheduled to meet five times over two years, is based upon nomination by sponsoring medical societies. John R. Martell, MD, Young Physician Section representative to the State Society's board of directors, and three other Pennsylvania physicians have been selected to participate on the Society's behalf.

The Consortium used an interactive software technique called IRIS to reach consensus about what organized medicine should look like in the future. Among the issues related to configuration that participants initially identified as critical for the future are: public credibility, responsiveness to diversity within the physician population, trustworthiness, financial stability, and the ability to build strategic alliances.

Between now and the next Consortium meeting in October, significant data collection will be undertaken by outside consultants to create further understanding of physician needs and desires for future organizational consideration.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

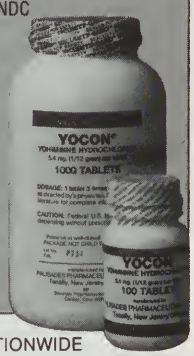
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Considering a Merger? Know Your Assets

The Health Care Group

The changing landscape of American health care has caused many physicians to consider merging their practices. Most physicians recognize that if they sell their practices, they are also selling the assets that are in the practice. The result is a close look at the market value rather than the book value of their assets. In a merger, however, where a physician's practice is being combined with others, a careful review of assets is often not done. This is a mistake.

An example

Suppose Dr. A and Dr. B merge their practices and agree to divide the ownership according to their previous income. Dr. A earned $150,000 and Dr. B earned $250,000. Out of a total income of $400,000, Dr. A earned 37.5 percent and Dr. B earned 62.5 percent. Accordingly, share ownership is divided 37.5 percent for Dr. A and 62.5 percent for Dr. B.

Both Dr. A and Dr. B have net assets worth $100,000 and both contribute these assets to the new practice. Dr. A decides the merger is not working out and wants to leave. Typically, agreements would provide a buyout for Dr. A where his or her proportionate ownership of the net book value of the practice would be paid out. Because Dr. A owns 37.5 percent of the practice, Dr. A would receive 37.5 percent of $200,000, or $75,000, as part of the buyout. Remember that Dr. A contributed $100,000 to the practice. Where did the $25,000 go? To Dr. B.

What to do?

Because physician incomes are often more related to work effort and reimbursement than to the value of assets, do not make ownership proportional to income. Income division can be governed by a separate agreement and closely related to the nature of the practice and wishes of the physicians. Instead, consider making ownership equal. Each merging physician has an equal say in how the practice is run; no one physician has a larger "hammer" with which to beat on the other members. This makes for much better inter-doctor relations and a more successful group.

If the value of the assets are not in proportion to the ownership, which is very likely, then adjust income until it is. Typically, this means that over the first year of the merger, those physicians with net assets in excess of their proportional ownership are paid for the difference by reducing the income of those physicians whose assets are below their proportional ownership share.

At the end of this process, the merged group has an income distribution plan that makes sense for everybody, and a share ownership accurately linked to the net book value that each physician contributed to the practice. Everyone has been treated fairly, and the new group is structured for the future.

What to watch out for

A physician should be aware of the following when focusing on an appropriate value for a practice's assets:

- *Assets that were purchased and written off, but still in use:* Assets that have value should be treated as such, regardless of their historical book value. Internal Revenue Code Section 179 allows thousands of dollars of equipment to be written off for tax purposes, and these assets are typically valued at zero on a practice's books. They should be restated for merger purposes at their fair market or economic value.
- *Assets that are in use, but completely depreciated:* All assets in use should be valued at no less than 20 percent of their cost, and depreciation should be restated to approximate the economic life of the asset. This revaluation process brings all practices to the same basis of asset valuation, and because each practice is treated equally, questions of fairness are minimized or eliminated.
- *Assets that are not typically recorded:* Pre-paid malpractice premiums can represent a significant asset for a practice. This should not be treated as valueless in a merger. Similarly, accounts receivable, payables, and other assets and liabilities should be carefully evaluated. Different mergers handle these items in different ways, but a merging physician should know what these accounts amount to.

In conclusion, merger agreements are almost always customized for the parties involved because of the many issues involved. But, in addition to looking at income division and what the future may hold, physicians considering merging their practices should always be aware of asset issues.

The contributing author, Zvi H. Weinman, MBA, is a consultant with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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Resources Available to Members

For more information on the complexities of mergers, request the State Society's "Medical Practice Merger Checklist," by calling the Department of Physician Services at (800) 228-7823.

The Society's expert staff can also answer questions regarding physician integration and can provide consultation services through the newest Society affiliate, PennMed Member Services Company.

OBITUARIES

Daniel H. Barenbaum, MD, *Philadelphia*
Temple University School of Medicine, 1941; age 77, died May 16, 1994. Dr. Barenbaum was a general practitioner.•

Walter P. Bitner, MD, *Honey Brook*
University of Pennsylvania School of Medicine, 1940; age 83, died April 16, 1994. Dr. Bitner was a psychiatrist.•

Charles R. Gennaria, MD, *Sun City, AZ*
Jefferson Medical College of Thomas Jefferson University, 1923; age 95, died April 4, 1994. Dr. Gennaria was a general practitioner.•

Felix E. Karpinski Jr., MD, *Wayne*
Jefferson Medical College of Thomas Jefferson University, 1944; age 74, died April 15, 1994. Dr. Karpinski was a pediatrician.•

M. Luther Kauffman, MD, *Glenside*
University of Pennsylvania School of Medicine, 1926; age 91, died April 17, 1994. Dr. Kauffman was an ophthalmologist.•

Edgar W. Kline, MD, *Lansdale*
Jefferson Medical College of Thomas Jefferson University, 1935; age 85, died April 14, 1994. Dr. Kline was a family practitioner.•

Vladimir J. Kolton, MD, *Reading*
University of Pennsylvania School of Medicine, 1951; age 67, died June 5, 1994. Dr. Kolton was a general practitoner.•

Emil W. Olson, MD, *Holland*
Temple University School of Medicine, 1931; age 89, died May 9, 1994. Dr. Olson was a general practitioner.•

Marjorie G. Morrison, MD, *Allentown*
University of Oklahoma College of Medicine, 1930; age 90, died June 1, 1994. Dr. Morrison was a psychiatrist.•

Samuel E. Penn, MD, *Pittsburgh*
Rush Medical College of Rush University, 1937; age 81, died April 13, 1994. Dr. Penn was an otolaryngologist.•

Ronald P. Savarese, MD, *Philadelphia*
Hahnemann University School of Medicine, 1968; age 51, died May 26, 1994. Dr. Savarese was a vascular surgeon.•

Maurice Seltzer, MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1926; age 92, died May 23, 1994. Dr. Seltzer was a general practitioner.•

Stanley W. Stanulonis, MD, *Shenandoah*
University of Pennsylvania School of Medicine, 1932; age 89, died April 11, 1994. Dr. Stanulonis was an internist.•

George E. Tomci, MD, *Edgewater Terrace*
University of Pittsburgh School of Medicine, 1954; age 71, died May 31, 1994. Dr. Tomci was a family practitioner.•

Charles W. Umlauf, MD, *Emmaus*
Temple University School of Medicine, 1943; age 74, died May 24, 1994. Dr. Umlauf was a psychiatrist.•

Listervelt S. Winfree, *Yeadon*
Meharry Medical College School of Medicine, Tennessee, 1943; age 81, died May 29, 1994. Dr. Winfree was a general practitoner.•

Judith Benscoter, DO, *Swarthmore*
Philadelphia College of Osteopathic Medicine, 1977; age 44, died April 9, 1994. Dr. Benscoter was an orthopedic surgeon.

Charles G. Brohm, MD, *Hawthorn*
University of Louisville School of Medicine, Kentucky, 1931; age 86, died May 14, 1994. Dr. Brohm was a general practitoner.

Franklin F. Campbell, MD, *Philadelphia*
Hahnemann University School of Medicine, age 73, died May 16, 1994. Dr. Campbell was a psychiatrist.

R. Jean Fleckenstine, MD, *Orangeville*
Woman's Medical College of Philadelphia, 1940; age 78, died April 3, 1994. Dr. Fleckenstine was a pediatrician.

Edward S. Gifford Jr., MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1933; age 86, died May 9, 1994. Dr. Gifford was an ophthalmologist.

Paul O. Klingensmith, MD, *Devon*
University of Pennsylvania School of Medicine, 1934; age 84, died March 16, 1994. Dr. Klingensmith was a gynecologist.

Robert L. Krigel, MD, *Philadelphia*
Mount Sinai School of Medicine of the City University of New York, 1975; age 44, died April 24, 1994. Dr. Krigel specialized in hematology/oncology.

Joseph J. Namey, DO, *Erie*
Kirksville College of Osteopathic Medicine, Missouri; age 73, died May 5, 1994. Dr. Namey was a general practitioner.

Adam J. Tomsykoski, MD, *Simpson*
Georgetown University School of Medicine, Washington, DC, 1950; age 67, died April 16, 1994. Dr. Tomsykoski was a general surgeon.

James E. Tuzinski, MD, *Bear Creek*
University of Cincinnati College of Medicine, Ohio, 1965; age 55, died April 7, 1994. Dr. Tuzinski was a plastic surgeon.

Anthony Watman, MD, *Allentown*
Tufts University School of Medicine, Massachusetts, 1921; age 96, died April 24, 1994. Dr. Watman was a surgeon.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

The Educational and Scientific Trust of the Pennsylvania Medical Society provides you with a way to make a significant statement honoring the memory of and paying tribute to your colleagues who are deceased.

Send your tax-deductible memorial gift to: The Educational and Scientific Trust of the Pennsylvania Medical Society, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

MEDICAL SCHOOL NEWS

ABC News Covers MCP Cap and Gown

"ABC Nightly News" covered the Medical College of Pennsylvania's (MCP's) cap and gown ceremonies on May 14 at the Philadelphia Academy of Music, in preparation for a report featuring MCP as the first U.S. medical school to start a women's health curriculum. The ABC report aired in early June.

The 118 members of MCP's class of 1994 completed their medical school training during a time of unprecedented growth and change at the medical school, founded as the first in the nation for women. In the past year, the school has taken the lead in the nation in women's health, establishing the first Institute for Women's Health and the first women's health education program.

MCP spokesperson Eryn Dobeck says, "These efforts are in response to the gender imbalance in traditional medical education and the growing body of knowledge emerging in women's health. Women comprise the majority of health care consumers, and they are demanding equal time in both research in women's health and women's health care."

AIDS and public health expert June Osborn, MD, professor of epidemiology and pediatrics at the University of Michigan, delivered the keynote address at the commencement. David E. Rogers, MD, the first Walsh McDermott University professor of medicine at the New York Hospital-Cornell University Medical Center received an honorary doctorate of medical science, and Edward Stemmler, MD, executive vice president of the Association of American Medical Colleges, received an honorary doctorate of human letters.

MCP reports that 57 percent of its class of 1994 will enter a residency program in a generalist specialty.

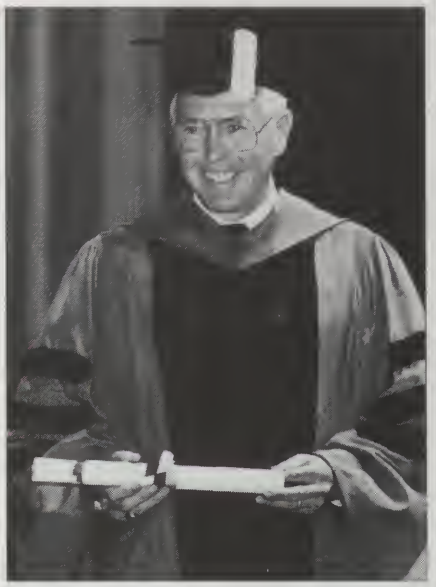
Margaret Delarese Larkins Pettigrew, MD, a member of the University of Pittsburgh School of Medicine's class of 1994, acknowledges the joy and relief of her own accomplishments, as well as her classmates'.

Hahnemann University

David Satcher, MD, PhD, director of the federal Centers for Disease Control and Prevention (CDC), spoke at Hahnemann University's commencement ceremonies on June 3, also at the Philadelphia Academy of Music.

Dr. Satcher, who received an honorary doctorate of science, presented "Revisiting the Dimensions of Excellence," in which he discussed changes in the health care system and medical education.

A total of 92 men and 66 women received medical degrees during the ceremony.



George Bernier Jr., MD, dean of the University of Pittsburgh School of Medicine, presented diplomas to 133 students at the medical school's commencement exercises in May.

Jefferson Medical College

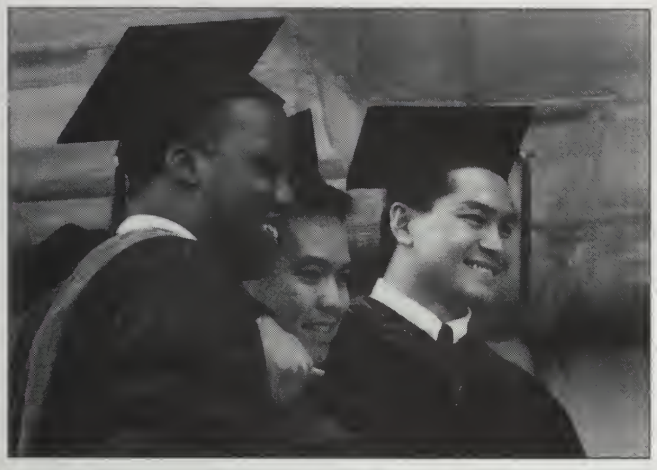
Jerome P. Kassirer, MD, editor-in-chief of *The New England Journal of Medicine*, and Takashi Sugimura, MD, president emeritus of the Japanese National Cancer Center, received honorary doctorates of science at Jefferson's 170th annual commencement on June 10 at the Academy of Music.

During commencement exercises, Thomas Jefferson University President Paul C. Brucker, MD, conferred degrees on 211 students of the medical college. R. Anthony Carabasi III, MD, professor of surgery and of radiology, and director of the Division of Vascular Surgery, served as grand marshal of the event.

Other medical schools

• One hundred and five students—62 men and 43 women—received medical degrees from Penn State's College of Medicine, Hershey, on May 15 at Founders Hall on the campus of the Milton Hershey School. Jo Ivey Boufford, MD, principal deputy assistant secretary of health and chief operating officer of the U.S. Public Health Service, presented the keynote address.

• The Philadelphia College of Osteopathic Medicine conferred DO degrees on 203 students at its



University of Pittsburgh School of Medicine graduates (left to right) Edward Leonard, MD; Dan Nguyen, MD; and Long Le, MD, pose for a photo after receiving their medical degrees in May.

graduation on June 5 at the Academy of Music.

• Temple University School of Medicine, Philadelphia, graduated 162 students, including 104 men and 58 women, on May 24 at the Academy of Music. Temple's class of 1994 dedicated its yearbook to Wallace P. Ritchie Jr., MD, PhD, professor and former chairman of the university's Department of Surgery.

• The University of Pennsylvania School of Medicine, Philadelphia, honored 142 students at its commencement ceremonies, held May 19 at the school's Irvine Auditorium. Samuel O. Thier, MD, president of Brandeis University, was the keynote speaker.

• Eighty-eight men and 45 women received MDs from the University of Pittsburgh School of Medicine on May 23 at Carnegie Music Hall, Pittsburgh. Henry Bahnson, MD, professor of surgery at the university's medical center, presented the main address; Carl Fuhrman, MD, professor of radiology at the medical center, led the students in the Declaration of Geneva; and Elmer Holzinger, MD, chair of the Department of Medicine at St. Francis Hospital, Pittsburgh, offered closing remarks.

RUSSIAN PHYSICIANS VISIT STATE SOCIETY

Twenty-three Russian physicians visited Pennsylvania Medical Society headquarters on May 13 as part of a $44 million project to design and evaluate comprehensive health system reform in the former Soviet Union.

The project, sponsored by the U.S. Agency for International Development, comprises three major strategies in the former Soviet Union:

1) provide technical assistance to test alternative health financing systems;

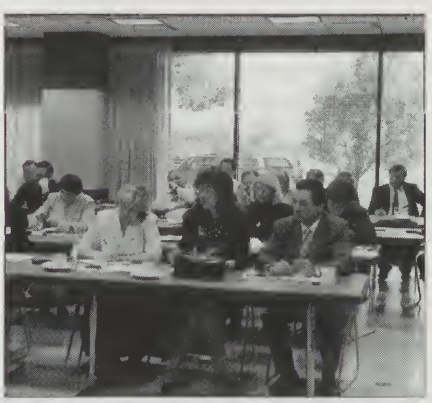
2) provide training for health care workers; and

3) test incentives which would reward increased efficiency and improved quality of health care services.

Donald G. Ferguson, MD, the Society's immediate past president, spoke to the visiting physicians. He began with an overview of the structure and purpose of organized medicine in the U.S., then moved to a discussion of how the U.S. health care system is changing and an explanation of managed care. Important factors in U.S. reform, he said, were controlling health care costs, reforming the legal system, and increasing the numbers and distribution of primary care physicians.

In conclusion, he said, "You stand at an important and exciting time in your history. You have the opportunity to look at the health care systems of many countries, including the U.S., and decide what will work best for your own countries and people. We are honored that you are looking at our system. We hope you will take the best, and leave the rest."

Following Dr. Ferguson's presentation, the Russian physicians met with members of the Pennsylvania Health Care Cost Containment Council to discuss data collection, research, quality assurance, and outcomes measurement; they concluded their day with a meeting with the governor.



Russian physicians learned about organized medicine and U.S. health system reform during a visit to State Society headquarters this spring.

Medical School News

• The Medical College of Pennsylvania inaugurated its 19th president, Leonard L. Ross, PhD, Bryn Mawr, in a ceremony in May.

• The University of Pittsburgh School of Medicine was ranked 18th among research-oriented medical schools in the U.S. by *U.S. News and World Report.* Also, the Pitt Graduate School of Public Health tied for eighth place among schools of public health offering master of public health degrees.

• The University of Pennsylvania School of Medicine, Philadelphia, has been ranked by the National Institutes of Health (NIH) as the fifth leading medical school in the nation in terms of overall federal research funding. The ranking is based on 1993 NIH research awards of $117.6 million.

• Hahnemann University, Philadelphia, has received a two-year, $90,000 grant from the Pew Charitable Trusts, in support of the university's community-based project, "Eating Good: Eating Right." Expanding on the existing family-centered efforts of Hahnemann's Public Health and Preventive Medicine Program, this project will take a hands-on, multidisciplinary approach to helping at-risk families improve the nutrition of mothers and their young children.

• Also at Hahnemann, members of the university's Student Interest Group in Fine Arts recently organized a month-long art exhibition to raise money for the school's Homeless Clinics Project.

COUNTY NEWS

CASEY PLAN GETS HARD TIME AT HEARING

Mercer County physicians and others interested in health system reform gathered at a Senate Public Health and Welfare Committee hearing, on May 26 at Penn State's Shenango Campus in Sharon, to debate the pros and cons of Governor Casey's proposed Health Security Act (Senate Bill 1202).

The governor's plan

R. David Myers, special assistant to the governor, opened the hearing with a 45-minute overview of the governor's plan, which, he said, is aimed at spending health dollars "more efficiently and more effectively." He highlighted several proposed provisions:

- While health care networks would be formed, consumers will continue to have a choice of physicians within the networks.
- A nine-member Health Security Board would develop for all Pennsylvanians a guaranteed benefits package that would include such services as routine doctor visits, preventive care programs, and child immunizations.
- A trust fund would be established to help pay for health coverage for Pennsylvanians who lose their jobs.
- The state would pay health insurance premiums for low-income people.

Panel response

As the nine panel members responded to Myers' presentation, Senator Robert D. Robbins (R-Mercer) moderated the discussion. "Most members of [the] panel...say Pennsylvania's health care system has flaws, but they disagree with the governor's plans for the system's major overhaul," *The Vindicator* of Youngstown reported. "Instead, they favor addressing specific needs within the existing system."

Joseph A. Giordano, MD, an internist from Sharon, was instrumental in planning the hearing and offered a number of statistics which support that America does not have a "broken" system. "President and Mrs. Clinton constantly state America's system is a 'broken' program. If this is true," he asked:

1) Why has infant mortality since 1960 decreased from 26 deaths per 1,000 live births to less than nine in 1991? and

2) Why does the U.S. have the lowest mortality per 100,000 population in bronchitis, myocardial infarction, stroke, and peptic ulcer disease compared to other developed countries?

Dr. Giordano also noted that 14 percent of the U.S. gross national product for health care is not readily converted to other countries since they do not include long-term care, dentistry, or elective procedures such as plastic surgery. He concluded that social issues—poverty, violence, drug abuse, etc.—"must be confronted for they have many health care ramifications."

James A. Jovenall, a Hermitage businessman and health insurance underwriter who recently underwent surgery for cancer, agreed with Dr. Giordano, saying, "This health care system does work. It isn't broken." Jovenall, Dr. Giordano, and several other panelists also had reservations and questions regarding coverage of Governor Casey's liver-heart transplant under the Health Security Act.

William A. Clepper Jr., administrator and chief executive officer of Clepper Convalescent Home, Sharon, called the governor's plan "over-idealistic and unrealistic," and said it lacked long-term care provisions. Joseph T. Morelli, DO, a Stoneboro family practitioner, said he is concerned about added bureaucracy.

Other panel members testifying included Meadville Medical Center President Anthony J. DeFail, and representatives of the insurance industry, labor, and the state pharmaceutical association.

Senator John E. Peterson (R-Venango), chairman of the Senate committee, concluded the four-hour hearing with his thoughts on "Health System Reform—Where Are We Headed?"

COMPLAINTS RECEIVED ON ANTI-ABORTION MAILERS

The State Society has received a number of complaints from Allegheny and Lehigh County physicians who have received anti-abortion postcards, tagged: "Abortion: The Quickest Way to Destroy Your Medical Career." The postcards were sent nationwide and to a variety of unrelated specialties.

While the Pennsylvania Medical Society does not take a position on abortion, it does recognize situations in which physicians may feel threatened or intimidated into performing or not performing a procedure that is legally permitted within parameters defined by federal and state law. Thus, the Society has contacted the U.S. Postal Service and other entities for guidance.

The Postal Service has deemed the cards legal and not personally threatening; therefore, it cannot legally pursue the mailer and cannot intervene at this time. However, it advises that consumers have the right to refuse to accept mail when it is delivered. Or, it adds, "After delivery, you may mark any mail matter, except registered, insured, certified, or C.O.D. mail, 'REFUSED' and return it unopened to the mail stream."

Another alternative for physicians who find the mailings threatening is to have your name removed from the mailing list. To do so, call Dalton Mailing Service at (214) 241-3991. You'll need to provide them with your name, address, and nine-digit zip code as they appear on the mailing label. Physicians may wish to keep previous mailings on file, in case concerns escalate in the future.

The State Society, along with several counties throughout the commonwealth, will continue to monitor the postcards; the Allegheny County Medical Society is collecting such mailings for further investigation.

A portion of this article was excerpted with permission from: Krah JG. Threats against physicians not to be taken lightly. Bulletin *83(6):194, 1994.*

AMA NEWS

SOCIETY RECEIVES DUES REBATE FROM AMA

The State Society has received $111,714 from the American Medical Association (AMA) as a 1994 dues rebate, the continuation of support following unification with the national organization in 1989.

In keeping with Society policy, 50 percent of the rebate was distributed to county medical societies. Seventy-five percent of that amount is for AMA dues reported by January 15, 20 percent for AMA dues reported

between January 16 and February 15, and five percent for AMA dues reported between February 16 and March 15.

PMSLIC OFFERS HOME-STUDY COURSE FOR 1995 DISCOUNT

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC), beginning this month, is offering "Risk Prevention Skills," a home-study program with a specialty section. Physicians who take the program and complete it by the October 14, 1994, deadline will earn a five-percent discount on their 1995 PMSLIC policy premiums and continuing education credits.

A $300 minimum and $1,000 maximum for an annual policy apply to the discount program. For more information and fee information, refer to the July issue of *Executive Report,* or call PMSLIC's Risk Management Department at (800) 445-1212 or (717) 558-7500.

STUDY OF UNINSURED REVEALS NEW INSIGHTS

A study of health care coverage in Pennsylvania confirms that the state's uninsured rate is among the lowest in the nation at 9.8 percent. Of the 980,000 currently uninsured Pennsylvanians, 818,000 are adults, ages 18-64, and 162,000 are children.

In the study, commissioned by the state's Blue Cross and Blue Shield, Pennsylvanians report a variety of reasons for not having health insurance:

- 376,000 cannot afford to purchase health insurance;
- 340,000 are unemployed;
- 215,000 have jobs which do not offer insurance;
- 51,000 do not want or need insurance;
- 39,000 cite that the employee share to purchase insurance is too expensive;
- 32,000 cite that coverage was dropped for health reasons; and
- 27,000 lost insurance when their parents' coverage was terminated or when they graduated from college.

Of the 9,000 state residents surveyed by telephone, 1,000 were identified as being uninsured for some period of time.

Blues recover $6 million

In other Blues news, fraud investigations conducted by Pennsylvania's Blue Cross and Blue Shield plans led to the recovery of more than $6 million in 1993. Anti-fraud specialists announced the recoveries at a recent National Health Care Anti-Fraud Association meeting, hosted by Pennsylvania Blue Shield.

FOUNDATION ACCEPTING 1995 GRANT NOMINATIONS

The Robert Wood Johnson Foundation (RWJF) is requesting nominations for the 1995 Generalist Physician Faculty Scholars Program from deans of four-year medical schools.

The program offers four-year career development awards to outstanding junior faculty in medical school departments/divisions of family practice, general internal medicine, and general pediatrics. The program is intended to strengthen general physician faculty in the nation's medical schools by improving their research capacity while maintaining their clinical and teaching competencies.

Thirty awards were made in the first two years of the program—1993 and 1994. Up to 30 awards will be made during the next two years, with approximately 15 faculty scholars selected each year.

Four-year grants of up to $60,000 annually will be made to sponsoring institutions to help cover the scholar's salary and research costs. Scholars are required to spend at least 40 percent of their time in research and other scholarly pursuits.

For more information and nomination guidelines, call Nancy E. Foster at (202) 687-2937. *Deadline for nominations: September 20, 1994.*

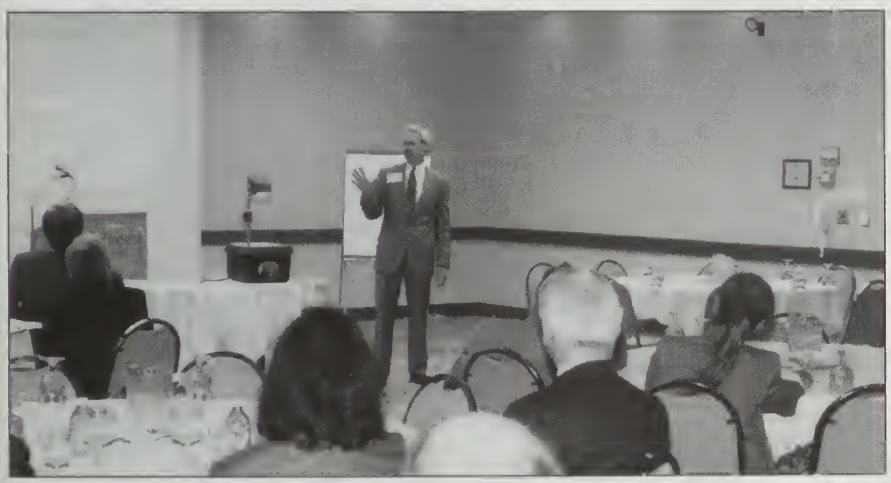
HEALTH INFORMATION AVAILABLE 24 HOURS A DAY

Consumers can now obtain free, published information 24 hours a day, seven days a week, through "AHCPR InstantFax," a multi-line fax-on-demand service operated by the Agency for Health Care Policy and Research (AHCPR).

Publications available through the agency's InstantFax include abbreviated versions of AHCPR-sponsored clinical practice guidelines, summaries of the agency's latest medical outcomes, and other research and announcements.

To access the service: Using a fax machine equipped with a touch-tone telephone handset, dial (301) 594-2800, push "1," and press the start button. AHCPR InstantFax will relay instructions.

DISTRICT NEWS



PHYSICIAN INTEGRATION TOPIC OF MEETING: Approximately 50 physicians attended a Sixth District meeting held in April at Toftrees Resort, State College. Counties represented included Blair, Centre, Clearfield, Huntingdon, Mifflin, and Juniata.

Society Executive Vice President Roger F. Mecum (pictured), the main speaker at the meeting, discussed future health care market trends, why physicians should consider integration, differences in integration models, critical success factors, and how to get started. A Q&A followed the presentation.

If your county medical society, medical staff, or physician group is interested in having a representative from the State Society speak on physician integration options, please call Frani Battista at (800) 228-7823, ext. 449.

KePRO—Looking to the Future

Donald E. Harrop, MD

In an effort to remain viable amidst the unknowns of health system reform and the future, the Keystone Peer Review Organization is broadening its financial base with other types of business interests.

I'm sure that most of the readers of these articles are well aware that the Keystone Peer Review Organization (KePRO) is a wholly owned subsidiary of the Pennsylvania Medical Society. But, I would wager that only a very small percentage know that KePRO is a "for-profit" corporation. This may be quite a surprise to some people, since most PROs and many of the other types of organizations which are under contract to the Health Care Financing Administration (HCFA) are nonprofit. But before anyone starts thinking that this may not be the best way to represent a physicians' membership organization, I would like to explain that there were several reasons for this type of corporate structure.

Dr. Harrop is president of the Keystone Peer Review Organization.

First of all, profit is not a dirty word. It is what this nation was built on. But KePRO was not founded for the purpose of making profits; it was started, as we have said in the past, because the State Society's Board of Trustees felt that as long as there was to be a peer review program, physicians should control it. And, as long as the Society was incorporating this new venture, it might as well attempt to make some money to help offset the need for higher membership dues. (At the time, there were also some tax advantages for our parent company.) And since we began, we have made some money and paid some dividends.

Now, with our HCFA Medicare contract being cut back more and more, and the unknowns of health system reform on the horizon, KePRO is looking to broaden its financial base with other types of business interests. We continue to believe that review of the necessity and quality of health care can and must only be done by physicians. We also feel an obligation to our staff who have done a fine job during the past nine years. Therefore, we intend to stay in business.

We have already been doing some review, separate from Medicare, for several years, including adjudication of disputed cases for the Blues, some workers' compensation review under the new Act 44, and all of the Medicaid review in Florida. But overall, with the exception of Florida Medicaid, these contracts don't amount to a lot of review—certainly not enough to offset the reductions in review volumes for Medicare. So, we knew that we would have to consider KePRO's future potential in light of presently available expertise and resources.

Therefore, the KePRO board and staff have become closely involved in a strategic planning process. We have employed a consulting firm to conduct a market analysis and product development study, and to develop a short-term marketing strategy. Out ultimate goal is to become much less dependent upon our HCFA Medicare contract so that, in the event health system reform is enacted and the role of the PROs is even further diminished, we would remain a viable organization. And yes, we would like to make some profits and continue to pay dividends to the Society in the future.

Quarterly Reports from KePRO Overseers

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. The following report of recently profiled data covers the period January 1 through March 31, 1994.

Inpatient Cases Reviewed: 13,910

	Number of Adverse Decisions	Number of Reviews	Rate
Admission Denials	206	12,652	1.62%
DRG Changes	181	11,825	1.53%
Confirmed Quality Problems	131	13,910	0.94%
Invasive Procedure Denials	5	4,784	0.10%
Day Outlier Denials	5	130	3.84%
Cost Outlier Denials	1	24	4.16%
Days of Stay Denials (Non-PPS Facilities)	0	1,098	0.00%

Ambulatory Surgery Cases Reviewed: 3,842

	Number of Adverse Decisions	Number of Reviews	Rate
Confirmed Quality Problems	303	3,842	7.88%
HCPCS/CPT Pay Group Changes	460	3,842	11.97%
Procedure Denials	60	3,842	1.56%

NEWSMAKERS

Gregory A. Formanek, MD, Hollidaysburg, has been named president of the Blair County Medical Society for a two-year term. Dr. Formanek is medical director for medical oncology, Mercy Regional Health System. He succeeds Andrew W. Gurman, MD.

James J. McKenna III, DO, Clarks Summit, has been elected president of the Lackawanna County Academy of Family Physicians. Dr. McKenna is the assistant medical director for the Geisinger Health Plan, Lackawanna County.

Richard W. Vassallo, MD, chief of cardiology and director of the Heart Station, Nazareth Hospital, Philadelphia, has been named to the hospital's board of trustees.

Zoraida Fiol-Silva, MD, director, Contact Lens Service, Wills Eye Hospital, Philadelphia, has been re-elected to the board of directors of the Contact Lens Association of Ophthalmologists (CLAO), for a three-year term. Dr. Fiol-Silva will be responsible for the control and management of the affairs and business of CLAO.

Mercy Hospital of Pittsburgh has named **Guy M. Stofman, MD,** chief of the Division of Plastic Surgery.

Arthur M. Feldman, MD, PhD, has been named Harry S. Tack professor of medicine, chief, division of cardiology, and director of the Pittsburgh Heart Institute, University of Pittsburgh Medical Center.

Joseph F. Novak, MD, Pittsburgh, received the Pennsylvania Academy of Ophthalmology's Humanitarian Service Award for his pioneering, lifelong effort to promote eye safety in the steel mills of Western Pennsylvania.

The Southwestern Pennsylvania Chapter of the American College of Surgeons has named the following officers: **Jonas T. Johnson, MD,** president; **James T. Hanlon, MD,** vice president and president elect; **Donald P. Atkinson, MD,** secretary; and **Frank T. Vertosick, MD,** and **Gary M. Ferguson, MD,** members of the council.

David B. Soll, MD, Philadelphia, gave three presentations on recent breakthroughs in his research on intraocular lenses at the annual meeting of the American Society of Cataract and Refractive Surgery in Boston, Massachusetts.

Jane Dorval, MD, senior vice president for medical affairs, Good Shepherd Rehabilitation Hospital, Allentown, and division chief of physical medicine and rehabilitation, Lehigh Valley Hospital, Allentown, spoke at a symposium, "Prevention of Secondary Conditions Associated with Spina Bifida and Cerebral Palsy," in Washington, DC.

Gary A. Melada, MD, Pittsburgh, was inducted as a fellow of the American College of Endocrinology.

Elsie R. Broussard, MD, DPH, University of Pittsburgh, was named the 20th Melitta Sperling Memorial Lecturer by the Psychoanalytic Association of New York.

In 1993, the *Philadelphia Business Journal* established Health Care Heroes awards to honor leaders in the local health care profession. These awards single out people, products, and organizations and are open to professionals and volunteers in the health care industry with offices located in New Castle County, Delaware; Burlington, Camden, and Gloucester counties in New Jersey; and Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania.

There are four categories of awards: most innovative new health care product or service, most significant cost-containment achievement, best accomplishment by primary care doctor, and most effective community health program.

The following are this year's recipients:

- **Joel W. Eisner, MD,** and **Lorraine F. Gutowicz, MD,** were recipients of the primary care physician category.
- *TotalCare* plan of the Keystone Health Plan East was the recipient of the new product or new program category.
- Albert Einstein's *A Better Start* project was the recipient of the community health program category.
- **David J. Shulkin, MD,** was the recipient of the cost-containment category.

Dr. Silberstein

Stephen D. Silberstein, MD, director, Comprehensive Headache Center, Germantown Hospital and Medical Center, Philadelphia, spoke at the Ninth Annual Headache Symposium entitled "Headache in the Decade of the Brain." Dr. Silberstein presented research that suggests definite links between migraines and female sex hormones.

John L. Melvin, MD, vice president, medical affairs, MossRehab Hospital, Philadelphia, gave a lecture on "Trends in Research in Rehabilitation Medicine in the USA" at the 31st Annual Convention of the Japanese Academy of Rehabilitation Medicine in Tokyo, Japan. Also, Dr. Melvin and **John Whyte, MD,** director, Moss Rehabilitation Research Institute, presented a paper entitled "Evaluation of Stroke: A Review" at the Post Congress Seminar on Evaluation of Impairment and Disability in Stroke Patients in Tokyo, Japan.

John P. McLaughlin, DO, clinical associate professor of medicine, Penn State's Milton S. Hershey Medical Center, was named a fellow of the American College of Physicians.

Eugene N. Myers, MD, professor and chairman, Department of Otolaryngology, University of Pittsburgh, was elected president elect of the American Board of Otolaryngology. Dr. Myers will become president in 1996 and will serve a two-year term.

James E. McHugh, DO, vice president of medical affairs, Suburban General Hospital, Norristown, was appointed to the National Board of Osteopathic Medical Examiners.

Philadelphia College of Osteopathic Medicine has named the following students as the recipients of the Christian R. and Mary F. Lindback Foundation Scholarship Award for the 1993-94 academic year: **Darlene L. Haupt; Matthew C. Haley; Eric D. Newman;** and **Robert D. Zenenberg**.

CLASSIFIED ADVERTISING

PHYSICIANS WANTED

Western Pennsylvania—Board Certified or prepared emergency physicians needed for staffing a community hospital emergency department near the Ohio/Pennsylvania border. Please send CV to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pennsylvania—Physician group seeks full-time and part-time physicians for an emergency department of community hospitals in central and western Pennsylvania. Please send resume to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pittsburgh, Pennsylvania—Penn Group Medical Association (PGMA), a 100-physician multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physicians in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves eight ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, and fringe benefits. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222, or call collect (412) 553-7502.

Physician Wanted—Internal Medicine/General Practice must be bilingual English/Spanish physician full- or part-time to join fine busy practice near Philadelphia suburb of Cheltenham. Please call M. Finnegan (215) 549-3000.

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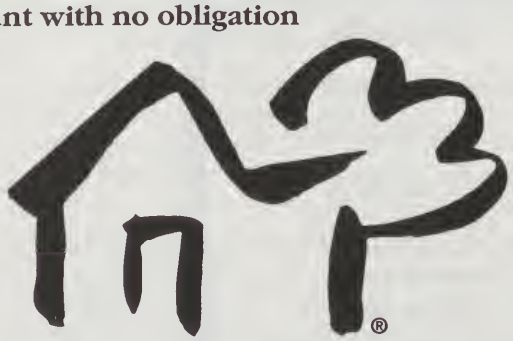

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Debunking a Fabricated Health Crisis

Marwan A. Wehbé, MD

This article is adapted from the Richard I. Burton, MD, Presidential Address, American Society for Surgery of the Hand, Kansas City, September 30, 1993. It was originally published with references in the Journal of Hand Surgery, *March 1994.*

Do the people of this country really want a health care service with the regulatory simplicity of the tax law, the frugality of the Pentagon, the efficiency of the Post Office, and the compassion of the IRS? Consider these facts:

Cost of care

Health care accounts for a small fraction of total business spending—less than four percent by most estimates. Physician fees account for only 19 percent of the dollars spent on health care, a percentage unchanged for the last 25 years! In fact, if doctors lowered their fees by 50 percent, the nation's health care bill would decrease by only two percent.

Consider that 70 percent of the price of a Cessna airplane is for product liability insurance. U.S. litigation costs are 95 percent of the price of DPT vaccine and have enabled foreign competition to seize the market. The U.S. has lost its international lead in contraceptive technology because of product liability.

If we subtract from the health "budget"—which is said to be at 14 percent of GNP—dollars which could be saved with tort reform (25 percent of health budget) and from a $1,000 yearly deductible (30 percent); and then subtract all non-medical costs such as those resulting from violence, drugs, tobacco, and speeding, our health care cost would be well *under* six percent of GNP.

Government control

Can you imagine the tax burden to all citizens and cost to all employers if the government promises that our society will guarantee housing, food, clothing, and health care for all citizens? We have food stamps for the poor, but we do *not* regulate the food prices at stores where the food is purchased.

Physician assistants and technicians cost less than physicians. Wouldn't it be more cost effective to eliminate the physicians altogether, and resign ourselves to care given by technicians and computers? There is also talk of de-emphasizing specialist care. By the same token, there is a push for an increase in primary care physicians, which would save money only if there is less care by specialists—that is, less definitive care for complex problems. *This is called rationing.* Rationing may increase overall society costs from unnecessary disability.

If the housing industry flourished, would we try to ration housing construction? If the Detroit auto industry led the world in innovation, research, and technology, would the government be allowed to take it over and ratchet it down, to force loss of jobs? Is the health care industry a growth industry with the product a healthier population? If so, should it be punished or encouraged?

Citizen control

Society can *save* a great deal by investing in good medical research and good health care. Government should therefore spend more on health care, not less!

Can the government guarantee health care? This is an economic issue, doubtful in itself. *Should* the government guarantee health care? This is a moral issue. Roosevelt stated in 1938: "The only sure bulwark of continuing liberty is a government strong enough to protect the interests of the people, and a people strong enough and well enough informed to maintain its sovereign control over its government."

Today, countries touted as models, such as England and Sweden, are backing away from socialism and starting to privatize. We must preserve the right of each patient to select his or her personal physician and the physician to select the best treatment for that patient. Managed *cooperation*, not managed *competition!* Citizens and patients must realize that they get what they are willing to pay for...with or without government interference.

It's not too late to reverse it all, but we must all act now to stop this madness. We must act as individuals via medical societies and via our patients—especially those influential in government and business, and the elderly. Do not wait to be asked. Step forward, volunteer, take initiative. Time is running out!

Dr. Wehbé is a hand surgeon at the Pennsylvania Hand Center and Bryn Mawr Hospital, Bryn Mawr.

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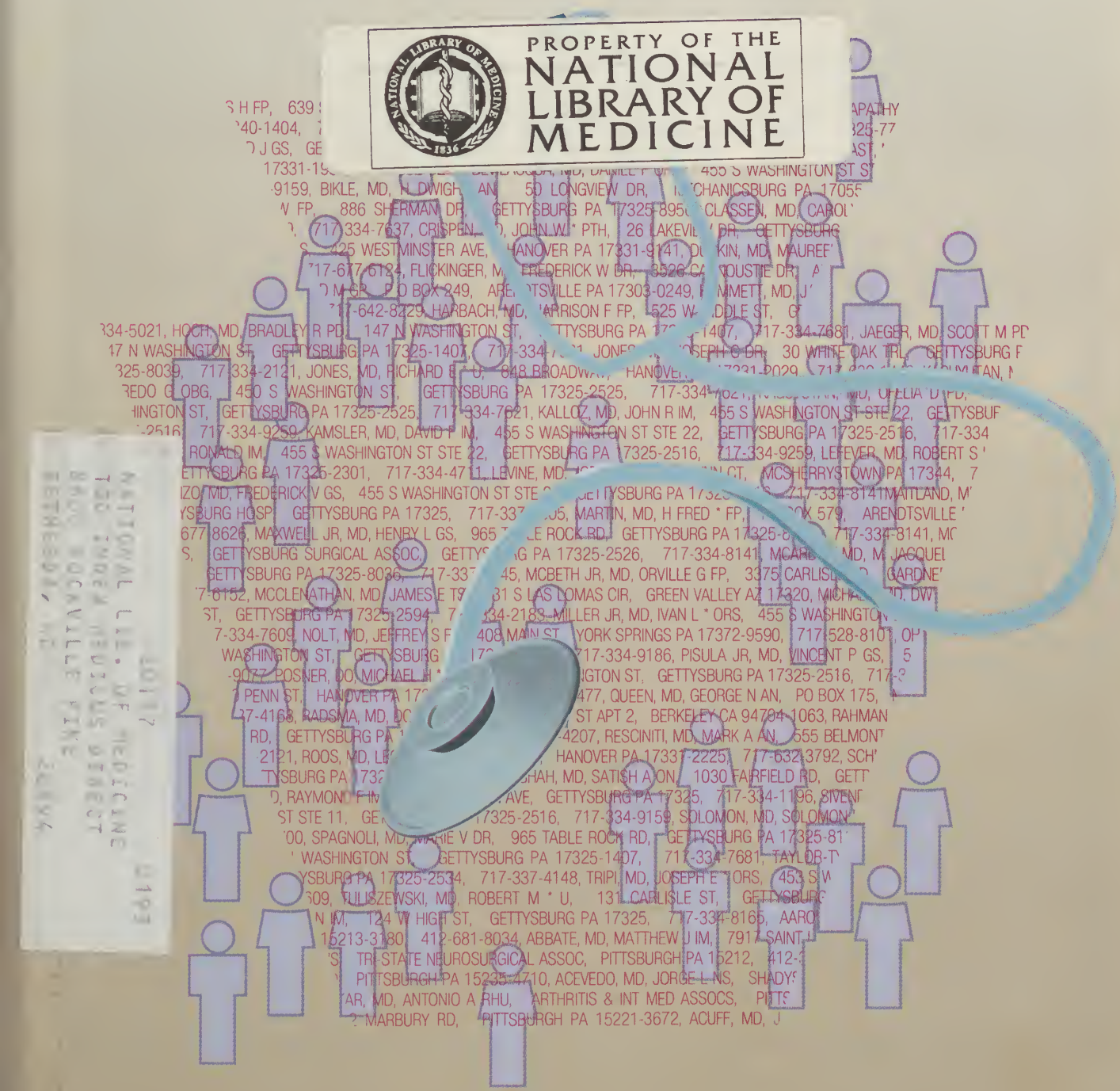

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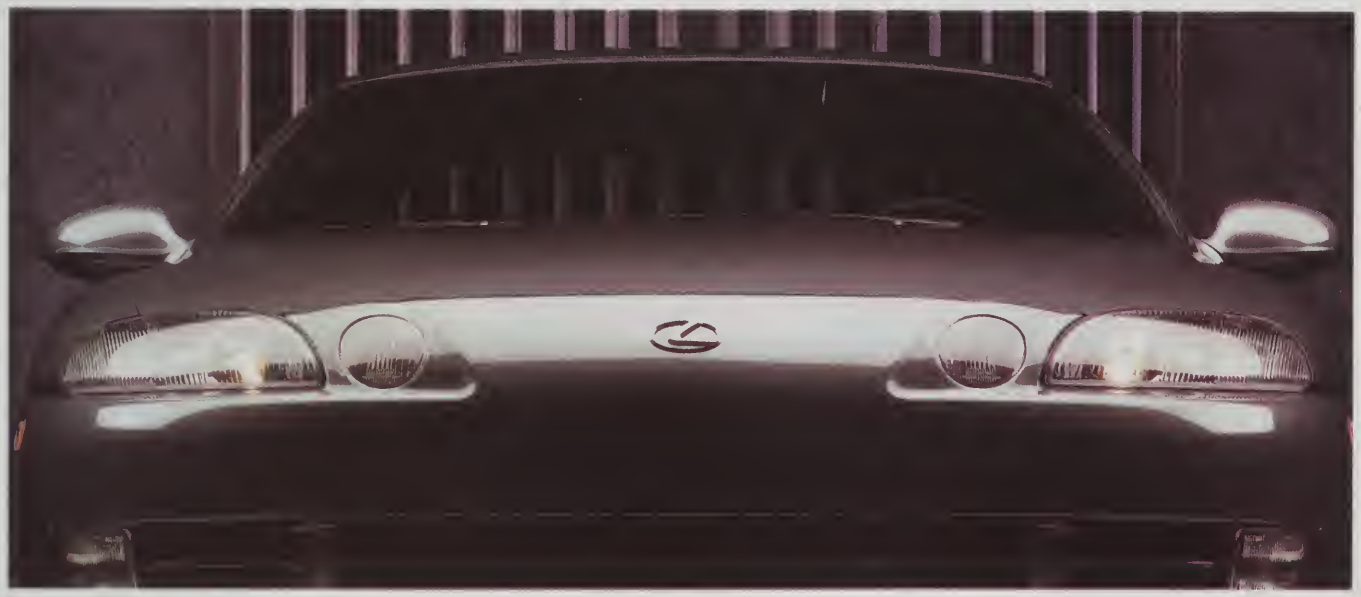

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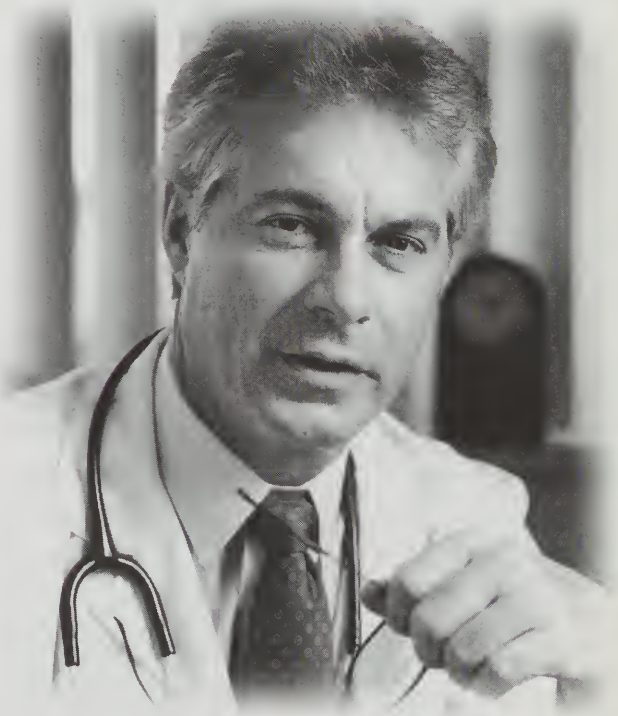

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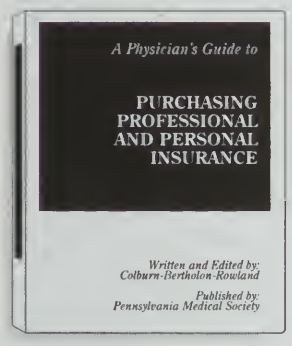

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SEPTEMBER 1994

September 7th
No Grand Rounds

September 14th
Diagnosis and Treatment of Ventricular Tachycardia
Leonard S. Dreifus, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Steven P. Kutalek, M.D.
Associate Professor of Medicine
Director, Clinical Cardiac Electrophysiology
Division of Cardiovascular Diseases
Hahnemann University

Scott E. Hessen, M.D.
Assistant Professor of Medicine
Associate Director
Clinical Cardiac Electrophysiology
Division of Cardiovascular Diseases
Hahnemann University

September 21st
Renal Tubular Acidosis
Neil A. Kurtzman, M.D.
Arnett Professor of Medicine
Chairman of Internal Medicine
Texas Tech Health Sciences Center
Lubbock, TX

September 28th
Polycythemia Vera: Understanding of Clinical, Viral and Genetic Mechanisms
Isadore Brodsky, M.D.
Professor and Associate Chair
Department of Medicine
Director of Hematology/Oncology
Hahnemann University

OCTOBER 1994

October 5th
Pulmonary Tuberculosis: Changing Pattern of Epidemiology and Therapy
Michael E. Iseman, M.D.
Associate Professor of Medicine
Mycobacterial Disease Service
Infectious Diseases Division
National Jewish Center
Denver, CO

October 12th
Coronary Heart Disease in Women
Nanette K. Wenger, M.D.
Professor of Medicine
Emory University School of Medicine
Director, Grady Health Systems
Atlanta, GA

October 19th
New Approaches to Infections in Organ Transplant Recipients
Robert H. Rubin, M.D.
Professor of Medicine
Harvard Medical School
Infectious Disease Division
Massachusetts General Hospital
Boston, MA

October 26th
Treatment of the Geriatric Patient
Joel Posner, M.D.
Professor of Medicine
Director, Division of Geriatrics
Medical College of Pennsylvania
Philadelphia, PA

NOVEMBER 1994

November 2nd
Clinical Diagnosis of Heart Disease for the Generalist
David H. Spodick, M.D., D.Sc.
Professor of Medicine
Cardiology Division
Saint Vincent Hospital
Worcester, MA

November 9th
Thyroid Disorders and the Heart
Paul Ladenson, M.D.
Professor of Medicine
Director, Division of Endocrinology and Metabolism
Johns Hopkins School of Medicine
Baltimore, MD

November 16th
Asthma: Management Strategies
William Busse, M.D.
Professor of Medicine
University of Wisconsin
School of Medicine
Madison, WI

November 23rd
No Grand Rounds—Holiday

November 30th
Kidney Stone Disease
Douglas M. Landwehr, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Nephrology and Hypertension
Allegheny General Hospital
Pittsburgh, PA

DECEMBER 1994

December 7th
To be announced

December 14th
Cardiac Auscultation
Leonard S. Dreifus, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Daniel Mason, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Gerald Scharf, D.O.
Professor of Clinical Medicine
Division of Cardiovascular Diseases
Hahnemann University

John J. Ross, RCPT
Research Assistant Professor
Division of Cardiovascular Diseases
Hahnemann University

December 21st
To be announced

December 28th
No Grand Rounds—Holiday

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

SEPTEMBER 21, 1994
Edema, Acid-Base, Electrolyte Disorders, Mechanisms & Treatment of Hypertension
Guest Lecturer:
Neil A. Kurtzman, M.D.

OCTOBER 5, 1994
Tuberculosis
Guest Lecturer:
Michael E. Iseman, M.D.

NOVEMBER 16, 1994
Asthma
Guest Lecturer:
William Busse, M.D.

DECEMBER 1994
To be announced

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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Professor of Medicine, Cardiovascular
Yale University School of Medicine
New Haven, CT

FRANZ H. MESSERLI, M.D.
"Heart and Hypertension in the Elderly"
Director of Clinical
Hypertension Laboratory
Ochsner Clinic
New Orleans, LA

J. KEVIN HARRISON, M.D.
"Clinical Assessment of Aortic and Mitral Valve Disease"
Assistant Professor Medicine
Cardiology Division
Duke University Medical Center
Durham, NC

MICHAEL ZIEGLER, M.D.
"Syncope and Postural Hypotension"
Director, Clinical Research Center
USC at San Diego Medical College
San Diego, CA

NICHOLAS TSAPATSARIS, M.D.
"Diseases of the Aorta"
Head, Section of Vascular Medicine and Hypertension
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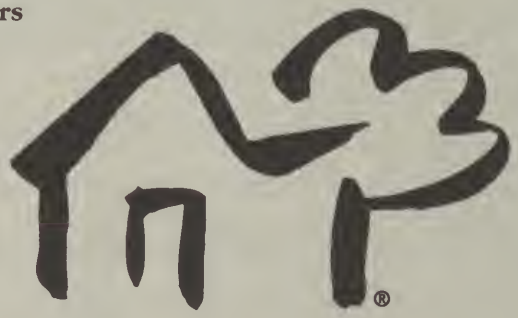

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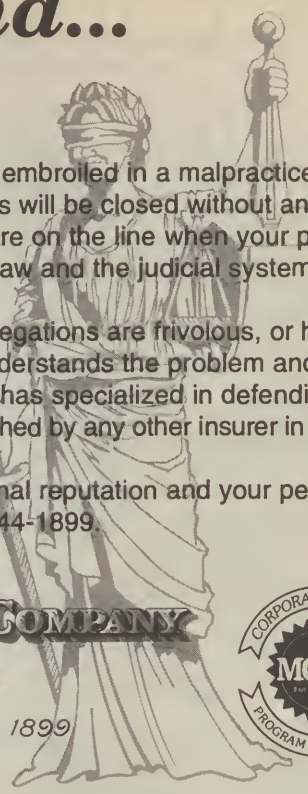

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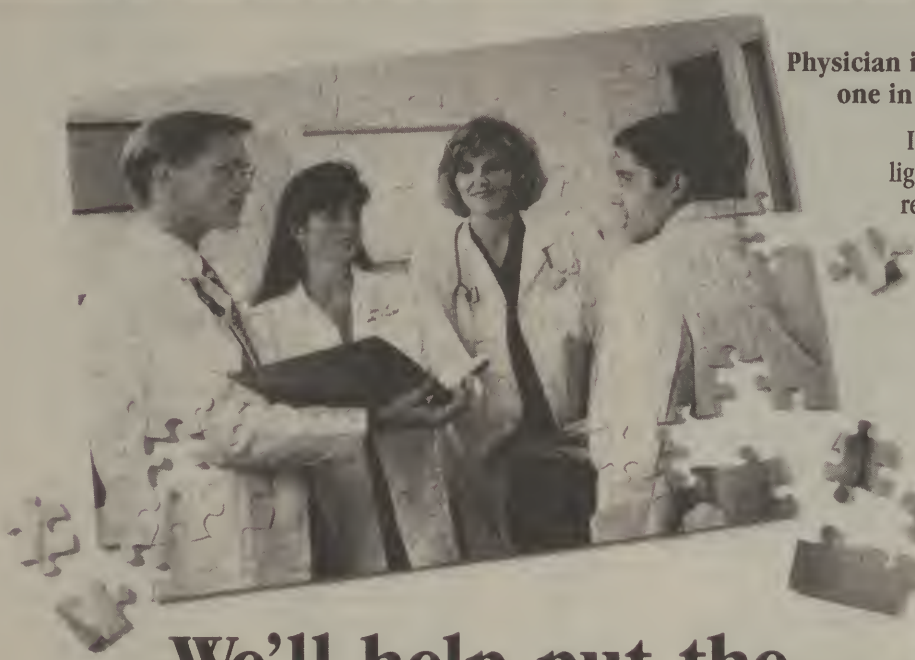

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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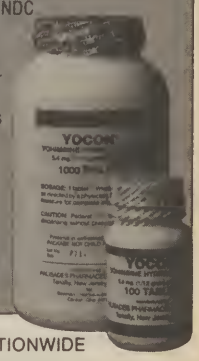
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al , The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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FFICIAL CALL TO 1994 MEETING

The 1994 annual meeting of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Hershey Lodge and Convention Center, Hershey, Pennsylvania, on Friday, October 21, at 10:00 a.m. The second session of the House is scheduled for Saturday, October 22, at 1:00 p.m., and the concluding session is Sunday, October 23, at 9:30 a.m.

ELECTIONS

In accordance with Chapter XII, Section 1 of the Bylaws of the Pennsylvania Medical Society, the following nominations and/or elections will be in order. Nominations for AMA delegates will be in order at the first session on Friday morning, October 21, 1994, and elections will occur on Saturday, October 22, 1994. Nominations for all other offices will be in order at the second session, Saturday afternoon, October 22, 1994, and elections will occur on Sunday morning, October 23, 1994.

General officers to be elected are a vice president, a speaker of the House of Delegates, and a vice speaker of the House of Delegates.

In accordance with Chapter XIV, Section 5 of the Bylaws, elections will be in order for a trustee for the Sixth District to succeed Edward H. Dench Jr., MD, Centre County, who is eligible for reelection; a trustee for the Seventh District to succeed William R. Beltz, MD, Lycoming County, who is eligible for reelection; a trustee for the Tenth District to succeed John W. Lehman, MD, Beaver County, who is eligible for reelection; a trustee for the Twelfth District to succeed Victor F. Greco, MD, Luzerne County, who is not eligible for reelection; a trustee for the Interspecialty Section to succeed James R. Regan, MD, who is eligible for reelection; a trustee for the Young Physicians Section to succeed John R. Martell Jr., MD, who is ineligible for reelection; and a trustee for the Medical Student Section to succeed Stacy L. Krisher, who is eligible for reelection.

In accordance with Chapter X, Section 1 of the Bylaws, elections for delegates and alternate delegates to the American Medical Association are in order. In accordance with Standing Rule Number 10 (adopted October 22, 1982), elections for delegates will be held on Saturday morning, October 22, 1994, and elections for alternate delegates will be held on Sunday morning, October 23, 1994.

Delegates whose terms expire December 31, 1994, are:

1. R. William Alexander, MD (Berks County)
2. Richard D. Baltz, MD (Dauphin County)
3. Doris G. Bartuska, MD (Philadelphia County)
4. Joseph B. Blood Jr., MD (Bradford County)
5. Betty L. Cottle, MD (Blair County)
6. James B. Donaldson, MD (Philadelphia County)
7. Victor F. Greco, MD (Luzerne County)
8. Lee H. McCormick, MD (Allegheny County)
9. John S. Parker, MD (Westmoreland County)
10. Howard A. Richter, MD (Delaware County)
11. Roberta L. Schneider, MD (Montgomery County)
12. Donald H. Smith, MD (Northampton County)

The Committee to Nominate Delegates and Alternates to the American Medical Association makes the following nominations for 12 delegates for two (2) years commencing January 1, 1995, and expiring December 31, 1996:

1. R. William Alexander, MD (Berks County)
2. Richard D. Baltz, MD (Dauphin County)
3. Doris G. Bartuska, MD (Philadelphia County)
4. Joseph B. Blood Jr., MD (Bradford County)
5. George F. Buerger Jr., MD (Allegheny County)
6. Betty L. Cottle, MD (Blair County)
7. James B. Donaldson, MD (Philadelphia County)
8. Jay L. Funkhouser, MD (Beaver County)
9. Victor F. Greco, MD (Luzerne County)
10. Lee H. McCormick, MD (Allegheny County)
11. John S. Parker, MD (Westmoreland County)
12. Howard A. Richter, MD (Delaware County)
13. Carl A. Sirio, MD (Allegheny County)
14. Donald H. Smith, MD (Northampton County)

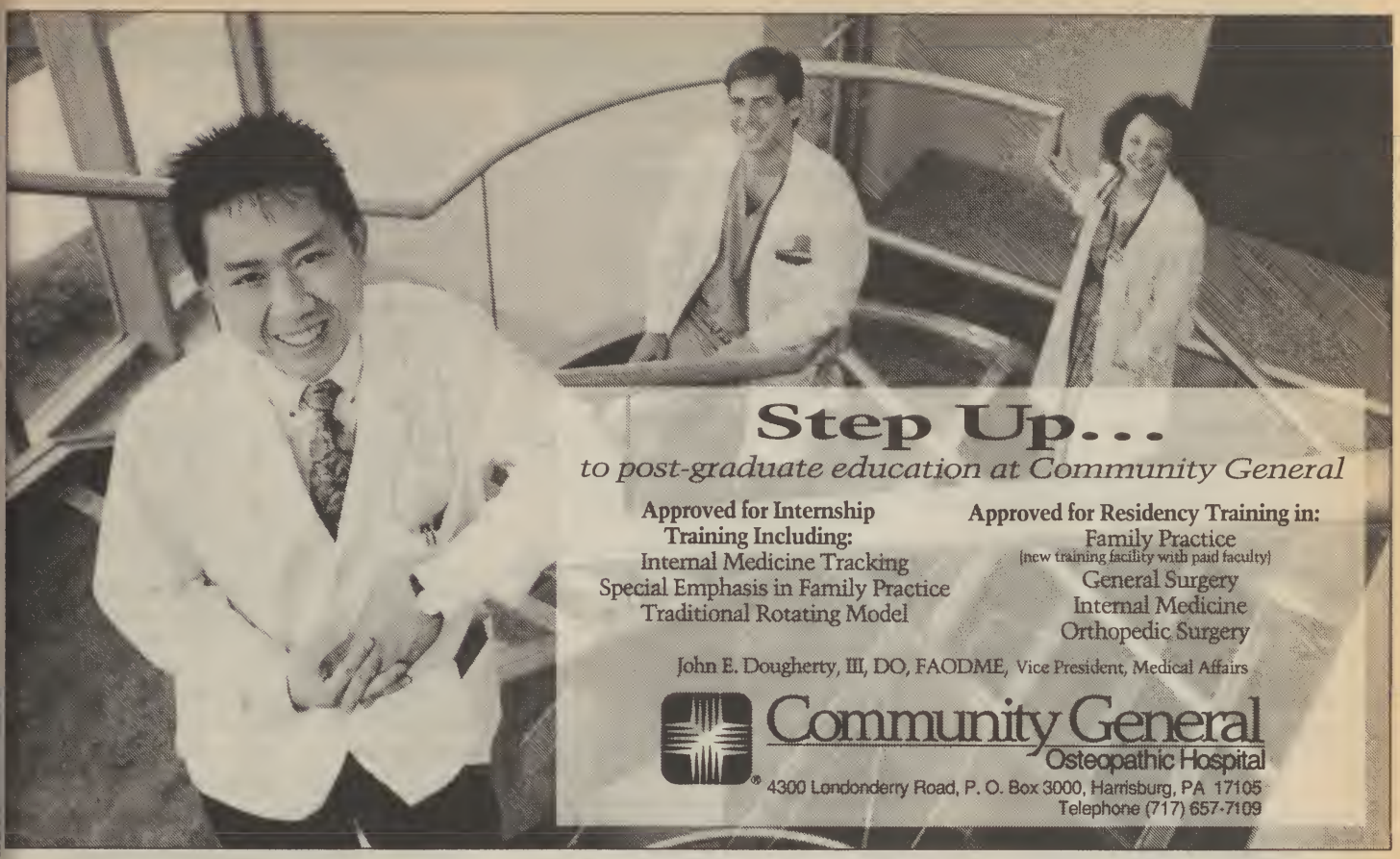
(Note: Dr. Schneider did not wish to be renominated for an AMA delegate position.)

Alternate delegates whose terms expire December 31, 1994, are:

1. Elias Abrutyn, MD (Philadelphia County)
2. George F. Buerger Jr., MD (Allegheny County)
3. Charles J. Cattano, MD (Allegheny County)
4. Robert G. Doe, MD (Lancaster County)
5. Thomas F. Freenock Jr., MD (Delaware County)
6. Mark S. Friedlander, MD (Delaware County)
7. Jay L. Funkhouser, MD (Beaver County)
8. Robert M. Kemp, MD (Lancaster County)
9. John A. Malcolm Jr., MD (Union County)
10. John D. Paletta (Allegheny County—slotted medical student position)
11. Carl A. Sirio, MD (Allegheny County)
12. Ferdinand L. Soisson Jr., MD (Cambria County)
13. Jennifer E. Trottman, MD (Montgomery County—slotted resident physician position)

The Committee to Nominate Delegates and Alternates to the American Medical Association makes the following nominations for 11 alternate delegates for two (2) years commencing January 1, 1995, and expiring December 31, 1996:

1. Raphael J. Bonita, MD (Luzerne County)
2. Charles J. Cattano, MD (Allegheny County)
3. Robert G. Doe, MD (Lancaster County)
4. Carl A. Frankel, MD (Dauphin County)
5. Thomas F. Freenock Jr., MD (Delaware County)
6. Mark S. Friedlander, MD (Delaware County)
7. George R. Green, MD (Montgomery County)
8. Andrew W. Gurman, MD (Blair County)
9. Virginia E. Hall, MD (Dauphin County)
10. Richard N. Harris, MD (Allegheny County)
11. Lila S. Kroser, MD (Philadelphia County)
12. Lynn M. Lucas-Fehm, MD (Philadelphia County)



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13. John A. Malcolm Jr., MD (Union County)
14. Robert S. Mathews, MD (Lancaster County)
15. Ferdinand L. Soisson Jr., MD (Cambria County)
16. L. Alan Wright, MD (Allegheny County)

(Note: Drs. Abrutyn and Kemp did not wish to be renominated for AMA alternate delegate positions.)

(Note: Should the House adopt Subject Nine calling for deunification, the Society would be entitled to two less delegates and alternate delegates.)

The Committee to Nominate Delegates and Alternates to the American Medical Association makes the following nomination for one slotted position for alternate delegate for a resident physician for a one-year term commencing January 1, 1995, and expiring December 31, 1995:

1. Jennifer E. Trottman, MD (Montgomery County)

The Committee to Nominate Delegates and Alternates to the American Medical Association has not yet received a nomination for the slotted position for alternate delegate for a medical student for a one-year term commencing January 1, 1995, and expiring December 31, 1995. Mr. Paletta did not wish to be renominated for this slotted position. Also to be elected will be three members to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. The term of Matthew Marshall Jr., MD (Allegheny County) expires; he is not eligible for reelection. The term of Donald E. Parlee, MD (Bucks County) expires; he is eligible for reelection. There will also be an election to fill the vacancy for the unexpired two-year term of John E. Devenney, MD (Montgomery County).

In accordance with Chapter XVII, Section 2 of the Bylaws, the Board of Trustees nominates the following members for two vacancies on the Judicial Council:

For the office now held by Raymond C. Grandon, MD (Dauphin County), who is eligible for reelection, the board nominates Raymond C. Grandon, MD.

For the office now held by David W. Clare, MD (Allegheny County), who is eligible for reelection, the board nominates David W. Clare, MD.

Set forth below is the text of the proposed bylaws revisions. Deletions from existing bylaws are indicated by brackets; additions are italicized.

SUBJECT ONE

ELIMINATION OF DUES CATEGORIES IN BYLAWS

The Board of Trustees, at its March 9, 1994, meeting, directed the Committee on Bylaws to prepare appropriate bylaws language for consideration by the board at its May meeting to eliminate references to dues categories in the bylaws. The proposed language, which was approved by the Board of Trustees at its May 11, 1994, meeting, is set forth below.

Chapter I - Membership
Section 3 - Membership Categories...
3.) Medical students enrolled in a medical school approved by this Society are eligible for active membership in this Society. Such students are not required to be members of a component county medical society, but must become members of the American Medical Association. They shall make application directly to this Society. Such students [shall pay such amount for a one- or four-year membership period as is fixed each year by the House after receiving recommendation from the Board of Trustees and] are entitled to all rights and privileges of membership. *Medical student active members shall pay such amount as is fixed each year by the House after receiving recommendation from the Board of Trustees....*

Chapter III - Assessments
Section 2 - Annual Assessment
The *full* annual assessment is to be fixed each year by the House of Delegates at the annual meeting [after opportunity has been given to the Board of Trustees to recommend the amount.] *following recommendation by the Board of Trustees....*

The full annual assessment is to be paid by all members of this Society. [Except that:

a. Senior members shall be required to pay 50 percent of the full annual assessment. A senior member is an active member of this Society who is 65 years old or older as of January 1 of the assessment year and who has been an active member of a constituent association of the American Medical Association for a total of 30 years.

b. Members on temporary military or other government service shall pay no assessment. Members in this category are active members who enter military or other government service for a period of less than four years and who enter service prior to March 1 of the assessment year or leave service after March 1 of the assessment year.

c. Residents who are active members of the State Society shall pay 10 percent of the full annual assessment for the calendar years subsequent to their first full calendar year as a resident member and otherwise shall pay no assessment.

d. Medical student active members shall pay such amount as is fixed each year by the House after receiving recommendation from the Board of Trustees.

e. Active members unable to practice because of illness or disability shall pay no annual assessment, provided the member's component society also levies no assessment.

f. Affiliate members shall pay 10 percent of the full annual assessment, except that a county medical society executive shall pay no assessment.

g. Active members shall pay no assessment for the period between the initial granting of a license to practice medicine in Pennsylvania and the end of the first full calendar year after the initial granting of the license; however, an active member, who previously paid no annual assessment or 10 percent of the full annual assessment because he was a resident, shall pay 50 percent of the full annual assessment for the period between the completion of a training program and the end of the first full calendar year of practice. An active member who pays no assessment or 50 percent of the full assessment under this subsection shall pay 75 percent of the annual assessment in the subsequent full calendar year. Physicians receiving their licenses within the same year as completion of their residency programs will be recognized in this newly licensed status providing they have not received a free year during residency.

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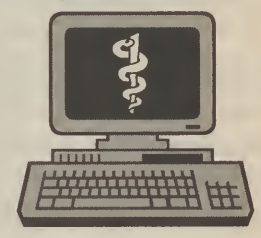

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h. Honorary members shall pay no annual assessment.

i. New members joining after November 1 of the assessment year shall pay no assessment, provided that the annual assessment for the relevant membership category is paid for the following year.

j. New members joining after July 1 of the assessment year, but before November 1, shall pay 50 percent of the annual assessment.

k. Associate members shall pay no annual assessment, except that if they elect to receive publications of the State Society, they shall pay (1) 10 percent of the full annual assessment each year, or (2) one full annual assessment in the year following the granting of associate status but no assessments thereafter.

l. Female physicians, who are active members, in the year after a maternity leave shall pay no annual assessment, provided the member's component society also levies no assessment.

m. Members in their first year of membership as active members in other than the resident or medical student categories shall be required to pay 90 percent of the full annual assessment if payment is made within 30 days of being billed. This subsection shall become effective upon adjournment of the 1994 House of Delegates.

n. Members in their first year of practice shall pay 20 percent of the full annual assessment; 40 percent in their second year; 60 percent in their third year; and 80 percent in their fourth year. The first-year membership discount, when applicable, shall further reduce payment in this category by 10 percent of the full active dues. This subsection shall become effective upon adjournment of the 1994 House of Delegates.] *The Board of Trustees may establish exceptions to the full annual assessment for categories of members. The Board of Trustees shall annually submit these categories of members to the House of Delegates for its approval. Pilot programs for dues category changes shall have no longer than a three-year cycle. These programs shall be submitted annually to the House of Delegates for its information until such time as final implementation is requested.*

Chapter IV - Funds
Section 1 - Special Funds...
The House of Delegates may require the Board of Trustees to allocate specific portions of the *full* annual assessments to such fund or funds....

Chapter IV - Funds
Section 3 - Medical Benevolence Fund
Each year the Board of Trustees, with the approval of the House of Delegates, may appropriate a sum not to exceed 15 percent of the *full* annual assessment for all active members to be allocated to The Educational and Scientific Trust of the Pennsylvania Medical Society....

Chapter IV - Funds
Section 4 - Educational Fund
Each year the Board of Trustees, with the approval of the House of Delegates, may appropriate a sum not to exceed 15 percent of the *full* annual assessment for all active members to be allocated to The Educational and Scientific Trust of the Pennsylvania Medical Society....

Chapter VIII - House of Delegates
Section 2 - Duties - In addition to the business to be conducted as prescribed in these bylaws, it shall be the duty of the House of Delegates to:...
c. fix the *full* annual assessment....

SUBJECT TWO

CHANGE IN QUORUM REQUIREMENT FOR HOUSE OF DELEGATES

The 1993 House of Delegates approved a recommendation from the floor of the House that the quorum requirement for the House of Delegates be changed from the current 75 delegates to 40 percent of the seated delegates. The Committee on Bylaws/ Reference Committee A recommended that the quorum requirement be changed from the current 75 delegates to 40 percent of the total allotted delegates. The proposed language is set forth below.

Chapter VIII - House of Delegates
Section 9 - Quorum - [Seventy-five] *Forty percent of the* seated delegates shall constitute a quorum to conduct business of any session of a meeting of the House of Delegates.

SUBJECT THREE

ESTABLISHMENT OF MEMBERSHIP CATEGORY FOR GROUP PRACTICE ADMINISTRATORS

The 1993 House of Delegates adopted Recommendation 2 of Board Report II calling for the establishment of a membership category for group practice administrators. The proposed language is set forth below. (*Note:* If Subject One is adopted, Subject Three becomes moot except for the creation of the membership category for group practice administrators. The addition to Chapter I, Section 3 of "or (8) group practice administrators." would remain; the three additional italicized sentences would be moot. The proposed language to Chapter III, Section 2 would also be moot.)

Chapter I - Membership
Section 3 - Membership Categories...
c. Affiliate Member - Upon recommendation and certification by the component society, any member of a component society not engaged in active practice within the jurisdiction of the component society may be an affiliate member of this Society and remain as such providing the individual is one of the following: (1) a physician who is a member of a national medical society of a foreign country; (2) an American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (3) a full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania; (4) a physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (5) a physician who is retired from active practice; (6) a physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society and the component society of the state society in the new state of residence; [or] (7) a county society

RESOLUTION DEADLINE FOR SOCIETY'S ANNUAL MEETING

Deadline for submission of resolutions for consideration by the 1994 Pennsylvania Medical Society House of Delegates is September 21, 1994. Late submissions require a two-thirds vote to become House business.

Any member of the Society may write a resolution. However, resolutions must be introduced by a delegate. For assistance, contact your county medical society's delegates to the House.

Send resolutions to: Kay Barrett, Pennsylvania Medical Society, P.O. Box 8820, Harrisburg, PA 17105-8820; or fax to: (717) 558-7840.

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B. Eliot Cole, M.D.,
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"The Psychiatric Management of Chronic Noncancer Pain Patients"
Carla Rodgers, M.D.,
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executive, who may or may not be a physician; *or (8) group practice administrators. Administrators of group practices that either pay for physician membership dues, or have a 50 percent or greater membership level, shall receive free memberships. Dues for administrators not qualified for free membership will be set at an amount equal to that currently paid by affiliate members. During recruitment efforts with group practices, this criteria may be waived in order to offer free membership to an administrator for a maximum of two years....*

Chapter III - Assessments
Section 2 - Annual Assessment - ...
f. Affiliate members shall pay 10 percent of the full annual assessment, except that a county medical society executive shall pay no assessment. *Administrators of group practices that either pay for physician membership dues, or have a 50 percent or greater membership level, shall receive free memberships. Dues for administrators not qualified for free membership will be set at an amount equal to that currently paid by affiliate members. During recruitment efforts with group practices, this criteria may be waived in order to offer free membership to an administrator for a maximum of two years....*

SUBJECT FOUR

TWO PERCENT DISCOUNT FOR EARLY PAYMENT OF DUES

The 1993 House of Delegates adopted Board Report F. Recommendation 2 called for offering, at the time of the next dues increase, a two percent discount to physicians who remit dues within the first 30 days of billing. The proposed language is set forth below. (*Note:* If Subject One is adopted, Subject Four becomes moot.)

Chapter III - Assessments
Section 4 - Payment of Assessments - The annual assessment, which is due January 1 of the assessment year, shall be paid through the member's component society to the executive vice president of this Society, except that the annual assessment of a medical student shall be paid directly to the executive vice president of this Society. The annual assessment, if not paid by March 1 of the assessment year, shall be considered a delinquent assessment. Provided, however, that the executive vice president may provide for installment payment of dues after March 1. [This provision shall become effective upon the adjournment of the 1994 House of Delegates.] *Physicians who remit dues within the first 30 days of billing shall receive a two percent discount. This provision shall become effective upon the next dues increase of the Society occurring after the 1993 House of Delegates....*

SUBJECT FIVE

REDUCED DUES CATEGORY FOR PHYSICIANS EARNING LESS THAN $60,000

The 1993 House of Delegates adopted Board Report FF. Recommendation 3 called for the establishment of a reduced dues category for physicians earning less than $60,000 adjusted gross practice income and that the reduction be 20 percent off the full active dues category. The proposed language is set forth below. (*Note:* If Subject One is adopted, Subject Five becomes moot.)

Chapter III - Assessments
Section 2 - Annual Assessment - ...
o. Physicians earning less than $60,000 adjusted gross practice income shall receive a reduction of 20 percent of the full active dues.

SUBJECT SIX

DATE JOINED BILLING SYSTEM

The 1993 House of Delegates adopted Resolution 93-51, Starting Dates of Membership, calling for the Society to amend its bylaws to provide that each member's year of membership begin during the month the member joins the Society; further, that each year the Society bill the member for the membership year beginning in that month. At its March 9, 1994, meeting, the Board of Trustees approved a recommendation from the Council on Membership, directing the Committee on Bylaws to develop appropriate bylaws language for consideration by the 1994 House of Delegates to change to a date joined billing cycle for all members; further, that the program be delayed one year before implementation. The proposed language is set forth below. (*Note:* If Subject One is adopted, the proposed amendments to Chapter III, Section 2 become moot.)

Chapter II - Component Societies
Section 7 - Membership Assessments - The secretary, [or] the treasurer, *or the designated agent* of each component society shall[, prior to January 1 of each year,] render an annual assessment to each member of said component society, indicating that payment of this assessment is due to this Society [on January 1 or will be considered delinquent if not paid before March 1.] *on the last day of the month in which the member joined the Society or the member will be considered delinquent.* Provided, however, that the executive vice president may provide for installment payment of dues [after March 1] *beyond the month joined of the assessment year.* This provision shall become effective upon adjournment of the [1994] *1995* House of Delegates....

Chapter III - Assessments
Section 2 - Annual Assessment - ...
a. Senior members shall be required to pay 50 percent of the full annual assessment. A senior member is an active member of this Society who is 65 years old or older [as of January 1] *in the year prior to the date joined* of the assessment year and who has been an active member of a constituent association of the American Medical Association for a total of 30 years.

b. Members on temporary military or other government service shall pay no assessment. Members in this category are active members who enter military or other government service for a period of less than four years [and who enter service prior to March 1 of the assessment year or leave service after March 1 of the assessment year]....

[i. New members joining after November 1 of the assessment year shall pay no assessment, provided that the annual assessment for the relevant membership category is paid for the following year.

j. New members joining after July 1 of the assessment year, but before November 1, shall pay 50 percent of the annual assessment.]....

Chapter III - Assessments
Section 4 - Payment of Assessments - The annual assessment, which is due [January 1

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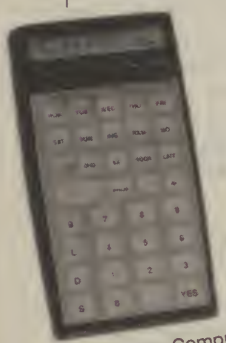

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of the assessment year] *in the month joined*, shall be paid through the member's component society to the executive vice president of this Society, except that the annual assessment of a medical student shall be paid directly to the executive vice president of this Society. The annual assessment, if not paid [by March 1] *in the month joined* of the assessment year, shall be considered a delinquent assessment. Provided, however, that the executive vice president may provide for installment payment of dues [after March 1] *beyond the month joined.* This provision shall become effective upon the adjournment of the [1994] *1995* House of Delegates. A special assessment shall be paid directly to the executive vice president prior to the due date of any special assessment.

Chapter III - Assessments
[Section 6 - Assessment Year - The calendar year shall be the assessment year for the purpose of the annual assessment of members and the fiscal operation of this Society.]

Chapter III - Assessments
Section [7] *6* - Other Income - ....

Chapter XVIII - Disciplinary Bodies/Proceedings and Appeals
Section 13 - Reinstatement of Membership After Termination - Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full [before December 31] *by the month prior to the month joined* of the assessment year and reinstatement by his component society. No such member under any circumstances shall be considered to be a member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of these bylaws....

SUBJECT SEVEN

GENDER-NEUTRAL LANGUAGE REVISIONS

Set forth below are proposed gender-neutral language revisions.

Chapter XIV - The Board of Trustees
Section 9 - Duties of Individual Trustees - [Each t]*Trustees* shall be the representatives of this Society for [his] *their* constituents and shall report on communications or visits with [his] *their* respective constituents to the Board of Trustees and further, report annually to the House of Delegates.

[Each t]*Trustees* shall help to strengthen organized medicine among [his] *their* constituents, be a source of information as to the status of the profession, increase the participation of [his] *their* constituents, and report annually to the House of Delegates.

[Each t]*Trustees* shall attend the meetings of the Board of Trustees and perform other such duties as may be assigned by the Board of Trustees.

[Each d]*District trustees* shall serve as chairs of all meetings of the district boards of censors of [his] *their* districts in accordance with these bylaws.

Chapter XIV - The Board of Trustees
Section 11 - Vacancies in Board Offices - Should the chair of the Board be incapacitated or unable to perform the duties of that office as determined by the Board of Trustees, then the vice chair shall act in [his stead] *place of the chair.*

Should both the chair and the vice chair of the Board be incapacitated or unable to perform their duties of office as determined by the Board of Trustees, then the Board shall elect a *new* chair and a vice chair from among its members [to act in their steads].

SUBJECT EIGHT

THE JUDICIAL COUNCIL

The Judicial Council has proposed the following bylaws changes for consideration by the 1994 House of Delegates.

Chapter XVII - The Judicial Council
Section 1 - Duties - The judicial power of this Society shall be vested in the Judicial Council. Its decisions shall be final, subject to the right of appeal to the [Judicial] Council *on Ethical and Judicial Affairs* of the American Medical Association as provided in the constitution and bylaws of the American Medical Association and in the bylaws of this Society....

Section 6 - *General Powers* - *The Council shall have such powers as are required to properly consider all questions of medical ethics and the interpretation of the bylaws, resolutions, and rules of this Society.*

The Council may determine that any provision, or the manner of adoption of any provision, of the bylaws or any resolution, rule, or other action of the House of Delegates is contrary to law or to the bylaws or to the duly adopted procedures, resolutions, or rules of this Society, and is therefore invalid in whole or in part. In such event, the Council shall forthwith report its action to the executive vice president of this Society, or in the absence thereof, to any officer of this Society. The executive vice president or such officer shall promptly call a meeting of the Board of Trustees to convene within 21 days from the date of such action by the Council. The purpose of the meeting shall be to effect the intent of the House of Delegates by some other means if such is possible within the powers granted to the Board of Trustees under the bylaws.

In acting on matters within its jurisdiction the Judicial Council shall not make any determinations based on its own policies, nor shall any of its decisions constitute legislation for this Society. Nothing contained in this section, however, shall prohibit the Council from interpreting the policies established by the House of Delegates or the Board of Trustees.

The Council also shall have power, at its discretion, to investigate general professional conditions and all general matters pertaining to the relations of physicians to one another or to the public. It may make such recommendations to the House of Delegates or the component societies as it deems necessary.

The Judicial Council shall not be bound by the rules of evidence used in courts. It may receive oral or written evidence judged by Council members to present the relevant facts.

Section [6] 7 - Original Jurisdiction
(a) The Council shall have original jurisdiction in:

[(a)] *(1)* all questions involving [membership in this Society or in a component society, or the rights and standing of members, whether in relation to other members, to component societies, to the State Society, or to the public, except as

such questions arise in connection with disciplinary proceedings instituted by any component society or any board of censors or other similar group;

(b) all controversies falling under] *interpretations of* the bylaws of this Society, or the Principles of Medical Ethics, [including] *but excluding* cases in which a member has been convicted of an offense or committed to an institution under a charge for which his medical license may be revoked, [but excluding] *and* all other controversies involving the discipline of a member *unless heard pursuant to subsection (3) below*; [and]

[(c)]*(2)* controversies between two or more component societies or their members[.] *; and*

(3) all other controversies involving the discipline of a member when a complaint is received by the Judicial Council pursuant to Section 1 of Chapter XVIII of these bylaws.

(b) Due Process - The Judicial Council may adopt necessary and appropriate rules and regulations relating to the consideration of original jurisdiction cases brought before the Judicial Council, except that in all cases heard by the Judicial Council pursuant to Section 1 of Chapter XVIII of these bylaws, the Council shall comply with the due process protections contained in the Model Bylaws for a Pennsylvania County Medical Society, Chapter XIV, with respect to content of the complaint and conduct of the hearing process, except that voting requirements and conflict of interest rules of these bylaws control.

(c) Decision - If the decision of the Judicial Council finds the member guilty of any of the charges, the decision shall state the penalty, if any, to be imposed. The penalty may be censure, suspension, expulsion from membership in this Society, or other penalty, regardless of any recommendation or suggestion for penalty made in the charges.

Section [7] *8* - Appellate Jurisdiction

(a) The Council shall have appellate jurisdiction to review the proceedings in disciplinary cases before any [intermediate appellate body created under the bylaws hereof,] *district board of censors* or before any final tribunal of any component society in appeals taken pursuant to the provisions of the bylaws of this Society. *On appeal, the Council may not overturn the facts of the case if supported by substantial evidence.*

(b) Due Process - When the Judicial Council is required to make a legal determination, such as in an appeal, or determinations with respect to interpretation of bylaws, questions of medical ethics, and resolutions and rules of the Society, the following shall apply: the member has the right to be represented by an attorney or by any other person of his choice; the member may present any matter pertinent to his defense.

Except in extraordinary circumstances as determined by the Council, the Judicial Council shall not receive new or additional evidence in appeal cases.

[Section 8 - General Jurisdiction - The Council shall have jurisdiction on all questions of medical ethics and on the interpretation of the bylaws, resolutions, and rules of this Society.

The Council may determine that any provision, or the manner of adoption of any provision, of the

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bylaws or any resolution, rule, or other action of the House of Delegates is contrary to law or to the bylaws or to the duly adopted procedures, resolutions, or rules of this Society, and is therefore invalid in whole or in part. In such event, the Council shall forthwith report its action to the executive vice president of this Society, or in the absence thereof, to any officer of this Society. The executive vice president or such officer shall promptly call a meeting of the Board of Trustees to convene within 21 days from the date of such action by the Council. The purpose of the meeting shall be to effect the intent of the House of Delegates by some other means if such is possible within the powers granted to the Board of Trustees under the bylaws.

In acting on matters within its jurisdiction the Judicial Council shall not make any determinations based on its own policies, nor shall any of its decisions constitute legislation for this Society. Nothing contained in this section, however, shall prohibit the Council from interpreting the policies established by the House of Delegates or the Board of Trustees if the statement of such policy is ambiguous.

The Council also shall have power, at its discretion, to investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public. It may make such recommendations to the House of Delegates or the component societies as it deems necessary.]

Chapter XVIII - Disciplinary Bodies/Proceedings and Appeals
Section 1 - Scope of Disciplinary Proceedings - No disciplinary proceedings shall be conducted by any body of this Society, except (a) a component society, (b) original disciplinary proceedings by the Judicial Council as provided in Section [3] *2* of this chapter, (c) referrals and appeals to district boards of censors as provided in Section 1 and Section [4] *3* of this chapter, and (d) appeals to the Judicial Council as provided in Section [5] *4* of this chapter.

a. Components' Boards of Censors - Each component society shall establish a county board of censors to be responsible for disciplinary proceedings involving members of the component society. Each county board of censors shall file a report on disciplinary activities annually with the secretary of this Society.

b. District Boards of Censors - Each component society shall elect a district censor who may not be a member of a grievance committee or the component society's board of censors or the Judicial Council of this Society.

1. The district censor shall serve on the district board of censors comprising the district censors from each of the component societies in the district.

2. The trustee from the district shall serve as chair[man] of the district board of censors without the right to vote.

3. In districts with fewer than three component societies, there shall be added to the district's board of censors the district censors of the adjoining component societies.

4. The district boards of censors shall have jurisdiction in all cases of appeals from the decisions of component societies as provided in these bylaws.

5. The district board of censors may receive cases for original jurisdiction when requested to do so by a county board of censors, or by the secretary of this Society, as described in subsection c of this section.

c. Communications Received by the Secretary - All written and signed communications received by the secretary of this Society, containing charges against a member which could require disciplinary proceedings, shall be forwarded by the secretary to the appropriate grievance committee. If the secretary shall not have received reasonable assurances within 45 days after receipt of the communication by the grievance committee that the grievance committee has considered the charges, *or if the secretary receives information from the complainant or from other sources that the charges have not been considered within the same time period,* the secretary [may] *shall* refer a copy of the communication to the county board of censors, *which may initiate original disciplinary proceedings. The grievance committee shall state in writing its reasons for not concluding the case, which writing shall be forwarded to the county board of censors.*

If the secretary shall not have received reasonable assurances within 45 days after receipt of a copy of the communication by the county board of censors that the county board of censors has considered the charges, *or if the secretary receives information from the complainant or from other sources that the charges have not been considered within the same time period,* the secretary [may] *shall* refer a copy of the communication to the district board of censors, which may initiate original disciplinary proceedings. *The county board of censors shall state in writing its reasons for not concluding the case, which writing shall be forwarded to the district board of censors.*

If the secretary shall not have received reasonable assurances within 45 days after receipt of a copy of the communication by the district board of censors that the district board of censors has considered the charges, or if the secretary receives information from the complainant or from other sources that the charges have not been considered within the same time period, the secretary shall refer the communication to the Judicial Council, which may, at its discretion, initiate original disciplinary proceedings. The district board of censors shall state in writing its reasons for not concluding the case, which writing shall be forwarded to the Judicial Council.

Section 2 - General Rules
(a) [Due Process - When the Judicial Council or the district boards of censors are required to make a determination with respect to the facts of a particular case, they shall comply with the due process protections contained in the Model Bylaws for a Pennsylvania County Medical Society, Chapter XIV, Sections 4 (as to content of the complaint) and 6, with the exception of subsection (H), which refers to voting.

When the Judicial Council is required to make a legal determination, such as in an appeal, or determinations with respect to interpretation of bylaws, questions of medical ethics, questions involving membership, and resolutions and rules of the Society, the following shall apply: the member has the right to be represented by an attorney or by any other person of his choice; the member may present any matter pertinent to his defense.

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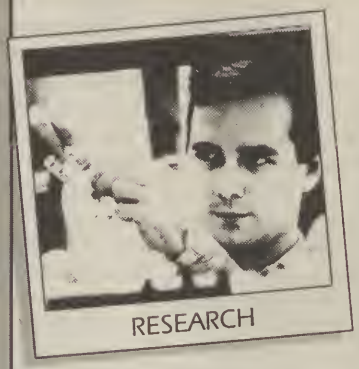

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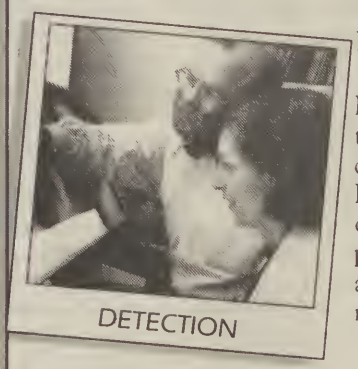

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Except in extraordinary circumstances, the Judicial Council shall not receive new or additional evidence in appeal cases.]

Conflict of Interest - Any member of the Judicial Council or the district board of censors who is in economic competition with the member against whom charges have been brought, or has any other conflict of interest, shall disqualify himself from participation in that particular case.

b. Decisions - The Judicial Council and the district boards of censors shall render their decisions with reasonable promptness. Decisions of the Judicial Council, whether in original proceedings or on appeals, shall be concurred in by a majority of the members of the Judicial Council present at the hearing, which shall be not less than three. Decisions of the district boards of censors shall be concurred in by a majority of the members of the district board of censors present at the hearing.

In the event of a tie vote in original proceedings before the Judicial Council, the charges against the member shall be dismissed. In the event of a tie vote in appeals, either by a district board of censors or by the Judicial Council, the decision appealed from shall be sustained.

All decisions of the Judicial Council and the district boards of censors shall be in writing. Copies thereof shall be given promptly to the interested parties. Copies of decisions of the district boards of censors shall be given promptly to the chair[man] of the Judicial Council.

[Section 3 - Original Disciplinary Cases Before the Judicial Council

a. Charges - In all cases of original disciplinary proceedings against a member of this Society before the Judicial Council as provided in these bylaws, the charge or charges upon which the proceeding is based must be brought by a majority vote of either the Board of Trustees or the district board of censors that has jurisdiction over the member's component society.

b. Decision - If the decision of the Judicial Council finds the member guilty of any of the charges, the decision shall state the penalty, if any, to be imposed. The penalty may be censure, suspension, or expulsion from membership in this Society, regardless of any recommendation or suggestion for penalty made in the charges.]

Section [4] *3* - Appeals to District Boards of Censors - Any member of a component society who has been censured, suspended or expelled thereby and any physician who has been refused membership by a component society or any component society aggrieved by the decision of another component society's board of censors shall have the right of appeal to the district board of censors for that district.

To have the right of appeal:

(a) written notice of the appeal must be given to the trustee of the district within [60] *30* days after the censure, suspension, expulsion, or notice of rejection of an application for membership (the failure of a component society to accept or reject an application for membership within six months after the filing thereof shall automatically be deemed a rejection at the end of said six months period); and

(b) a brief outlining the basis of such appeal must be presented to said trustee within [90] *60* days after either of the events heretofore mentioned.

Section [5] *4* - Appeals to the Judicial Council - Any member of any component society or any component society aggrieved by a decision of a district board of censors may appeal from such decision. Such member or society must give written notice of said appeal to the Judicial Council within [60] *30* days after the date of the decision of the district board of censors and must submit a brief, outlining the basis of such appeal, to the Judicial Council within [90] *60* days after the decision of the district board of censors. The action of the Judicial Council in cases of appeals shall be limited, except in extraordinary circumstances, to a review of the record of the proceedings [before the district board of censors].

Section [6] *5* - Appeals to the [Judicial] Council *on Ethical and Judicial Affairs* of the American Medical Association - Any component society or any member of the American Medical Association aggrieved by a decision of the Judicial Council of this Society may appeal such decision to the [Judicial] Council *on Ethical and Judicial Affairs* of the American Medical Association in accordance with the bylaws and rules thereof. If such right of appeal is not exercised, then the effective date of decisions as prescribed in these bylaws shall prevail.

Section [7] *6* - Effective Date of Decisions of Component Societies, District Boards of Censors and the Judicial Council - No action of any component society censuring, suspending, or expelling a member and no action of any district board of censors affirming any such action shall become effective so long as the member has any right of appeal according to these bylaws, or during the pendency of any such appeal.

All decisions of the Judicial Council, whether in original proceedings or on appeals, shall become final upon the issuance thereof, except that any such decision involving a member of the American Medical Association shall not become effective until 30 days after the decision of the Judicial Council, and, if the member or the component society, if any, has given written notice to the Council on Ethical and Judicial Affairs of the American Medical Association during said 30-day period of his or its intention to appeal to that body and furnishes a copy of such notice to the Judicial Council of this Society, and, in the case of a member, to the secretary of his component society, until the expiration of the appeal period and the final disposition *by* the Council on Ethical and Judicial Affairs of the American Medical Association.

Section [8] *7* - Notification of Expulsion - Written notification of all final decisions expelling a member for disciplinary reasons shall be given to the appropriate licensing body and the appropriate hospital medical staff.

Section [9] *8* - Automatic Suspension - Any member of this Society convicted by a court of competent jurisdiction of committing a felony or any crime involving moral turpitude, shall be automatically suspended for an indefinite period. It shall be the duty of the secretary promptly to inform the appropriate county board of censors of any such conviction of any member of this

Society, however, any member of the Society having any such information should promptly report the same to the county board of censors.

The county board of censors shall make due inquiry. If it finds that such member has, in fact, been so convicted, the county board of censors shall order a certified copy of the conviction from the court and upon receipt thereof shall file said copy with the member's records. The county board of censors shall thereupon notify the member that he will stand suspended from membership for an indefinite period, beginning 90 days following his conviction by the court, or 10 days following the notice if such notice is issued more than 90 days after the conviction, unless prior to the effective date of the suspension, the member certifies to the county board of censors that he has filed an appeal from the conviction.

If the member so convicted has so appealed, the suspension from membership shall be stayed until such time as the appeal has been finally disposed of by a court of last resort. Such suspension shall be completely nullified in the event the court reverses the member's conviction.

Section [10] *9* - Other Suspensions of Membership - A member shall be suspended from membership in this Society:

(a) on December 31 of any year if he is an active or associate member who has failed to qualify for the American Medical Association's Physician's Recognition Award provided the office of the executive vice president has given such member 60 days notice prior to December 31 that such suspension will be invoked unless such member shall submit sufficient supplemental records to fulfill such award requirements by December 31, and such suspension shall remain in force until such member submits sufficient supplemental records to fulfill the award requirement;

(b) upon suspension of his membership in his component society; and

(c) upon the effective date, as provided in these bylaws, of an order to that effect issued by the Judicial Council of this Society or a district board of censors.

Section [11] *10* - Rights of Members During Suspension - The suspended member shall not be entitled to exercise any of the rights and privileges of membership during the period of suspension, but shall continue to be obligated for the payment of annual assessments without any reduction whatsoever.

Section [12] *11* - Termination of Membership - The membership of a member of this Society shall terminate:

(a) in the case of active or associate members suspended who have not completed the continuing medical education requirement for the American Medical Association's Physician's Recognition Award by the end of a one year period of suspension;

(b) upon (i) termination of his membership in his component society for any reason whatsoever, or

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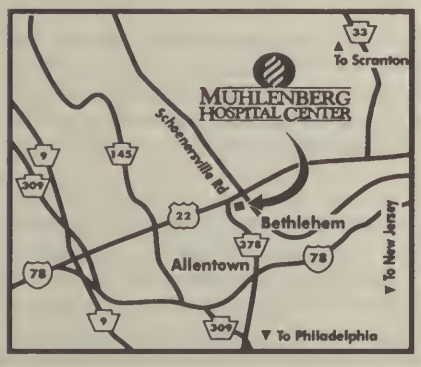

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(ii) failure to pay a delinquent assessment within 30 days after notice of such delinquency as provided in these bylaws, or (iii) three months after ceasing to be eligible for the class of membership in which he is a member as specified in these bylaws, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the executive vice president of this Society; and
(c) upon the effective date, as provided in these bylaws, of an order to that effect issued by the Judicial Council of this Society or a district board of censors.

Section [13] *12* - Reinstatement of Membership After Termination - Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year and reinstatement by his component society. No such member under any circumstances shall be considered to be a member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of these bylaws.

Any active dues-paying or associate member whose membership has been terminated for failing to meet the requirements for the American Medical Association's Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the required hours were earned during the previous 12 months.

Any person whose membership has been terminated for failure to pay a special assessment shall be reinstated upon payment of the delinquent special assessment.

Section [14] *13* - Reinstatement of Membership After Automatic Suspension - Any member indefinitely suspended from membership pursuant to the provisions of Section [9] *8* of this chapter may be reinstated to full membership after a period of six months from the effective date of the suspension.

Applications for reinstatement may be submitted not earlier than four months after the effective date of the suspension. Applications shall be in writing and shall set forth the reasons why the member believes he is entitled to reinstatement. They shall be filed with the county board of censors.

The county board of censors, after due inquiry, shall meet to consider the application. The suspended member shall be reinstated upon a majority vote of the members of the county board of censors present and voting at the meeting, provided that there is a quorum of at least four members.

Section [15] *14* - Expulsion of Unqualified Witness - Any member of this Society who testifies as an expert witness without meeting the qualifications set forth in this section shall be subject to expulsion after a due process hearing as provided for in these bylaws. An expert witness must have basic educational and professional knowledge as a general foundation for his testimony, and in addition, have current personal experience and practical familiarity

with the problems that are being considered and be actively engaged in the practice of the medical subject under discussion.

SUBJECT NINE

DEUNIFICATION

The following proposed bylaws amendments have been submitted with the requisite number of signatures of active or associate members of the Delaware County Medical Society for consideration by the 1994 House of Delegates.

Restated Articles of Incorporation...

Article VII. Membership in the Corporation shall be limited exclusively to persons who are members in good standing of a county medical society duly affiliated with the Corporation, and the failure on the part of any such member to keep himself or herself in good standing in such affiliated county medical society [and the AMA] shall be sufficient cause for expelling the member from the Corporation, either by automatic termination of membership or otherwise as the Bylaws of the Corporation shall provide. Nothing herein shall be construed to prevent the Corporation from electing honorary members, medical students, or special members from among persons who are not members in good standing of affiliated county medical societies.

Chapter I - Membership
Section 2 - Admission to Membership - To be a member of this Society a physician must be a member of a component society. The term, physician, means a person who has received formal and recognized training in the art and science of medicine and is qualified to acquire an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Once elected to a category of membership other than honorary, in a component society, the member is required to become a member of this Society [and the American Medical Association] within three months by paying any appropriate assessment and having the component society certify to the executive vice president of this Society that the member possesses the qualifications for the category as described in these bylaws.

Chapter I - Membership
Section 3 - Membership Categories
a. Active Member: ...
3.) Medical students enrolled in a medical school approved by this Society are eligible for active membership in this Society. Such students are not required to be members of a component county medical society[, but must become members of the American Medical Association]. They shall make application directly to this Society....

Quarterly Report of House Available

In accordance with Resolution 92-27 of the House of Delegates, the quarterly report on actions of the House is now available from the State Society. The report is provided to members to enable them to respond to and participate in upcoming House activities. To request a copy, call (800) 228-7823, extension 403.

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Send resolutions to:

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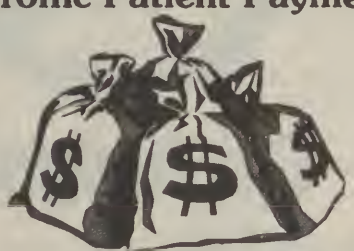

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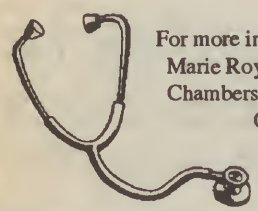

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References: 1. *A Report of the Surgeon General: Smoking and Health*, publication 79-50066. US Department of Health, Education, and Welfare, 1979. 2. Bouknight LG, Bouknight RR: Cocaine—a particularly addictive drug. *Postgrad Med* 1988;83(4):115-131. 3. Derlet RW: Cocaine intoxication. *Postgrad Med* 1989;86(5):245-253. 4. Buchanan JF: Cocaine intoxication: A review of the presentation and treatment of medical complications. *Hospital Phys* 1988;3:24-28.

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The roster is coded with specialty information in the county society section. The abbreviation that appears to the right of the physician's name is the specialty code. *This specialty information was supplied from AMA records or by the physician personally and does not necessarily imply Board certification in the specialty.* These codes and the specialties that they represent, along with the approximate number in each specialty, are as follows:

*** Indicates membership in the Pennsylvania Medical Political Action Committee**

ADL	Adolescent Medicine	3
AI	Allergy and Immunology	74
AM	Aerospace Medicine	2
A	Allergy	50
AN	Anesthesiology	933
ATP	Anatomic Pathology	9
BE	Broncho-Esophagology	1
BLB	Blood Banking	3
CCM	Critical Care Medicine	6
CD	Cardiovascular Diseases	693
D	Dermatology	283
DMP	Dermatopathology	6
DIA	Diabetes	18
EM	Emergency Medicine	316
END	Endocrinology	80
FP	Family Practice	1,747
FPS	Facial Plastic Surgery, Otolaryngology	4
GE	Gastroenterology	270
GO	Gynecological Oncology	5
GP	General Practice	829
GPM	General Preventive Medicine	17
GER	Geriatrics	48
GYN	Gynecology	84
HEM	Hematology	102
IG	Immunology	2
ID	Infectious Diseases	91
IM	Internal Medicine	2,340
LAR	Laryngology	1
LM	Legal Medicine	3
MFM	Maternal and Fetal Medicine	5
MFS	Maxillofacial Surgery	1
ND	Neoplastic Diseases	5
NEP	Nephrology	126
N	Neurology	257
NPM	Neonatal-Perinatal Medicine	30
CHN	Neurology, Child	15
NA	Neuropathology	4
NM	Nuclear Medicine	52
NR	Nuclear Radiology	0
NTR	Nutrition	4
OBS	Obstetrics	2
OBG	Obstetrics/Gynecology	989
OM	Occupational Medicine	92
ON	Oncology	149
OPH	Ophthalmology	690
OT	Otology	3
OTO	Otolaryngology	374
PTH	Pathology	331
CLP	Pathology, Clinical	21
FOP	Pathology, Forensic	1
PD	Pediatrics	948
PDA	Pediatrics, Allergy	20
PDC	Pediatrics, Cardiology	22
PDE	Pediatric Endocrinology	7
PHO	Pediatric Hematology-Oncology	13
PNP	Pediatric Nephrology	2
PVD	Peripheral Vascular Disease	4
PA	Pharmacology, Clinical	13
PM	Physical Medicine/Rehabilitation	308
P	Psychiatry	667
CHP	Psychiatry, Child	57
PYA	Psychoanalysis	19
PH	Public Health	17
PUD	Pulmonary Diseases	183
RO	Radiation Oncology	54
R	Radiology	425
DR	Radiology, Diagnostic	511
PDR	Radiology, Pediatric	13
TR	Radiology, Therapeutic	70
REN	Reproductive Endocrinology	9
RHU	Rheumatology	110
ABS	Surgery, Abdominal	6
CDS	Surgery, Cardiovascular	95
CRS	Surgery, Colon and Rectal	66
GS	Surgery, General	1,032
HS	Surgery, Hand	18
HNS	Surgery, Head and Neck	8
NS	Surgery, Neurological	195
ORS	Surgery, Orthopedic	732
PDS	Surgery, Pediatric	21
PS	Surgery, Plastic	172
TS	Surgery, Thoracic	97
TRS	Surgery, Traumatic	14
U	Surgery, Urological	373
VS	Surgery, Vascular	51
OS/US	Other, i.e., physician designated a specialty other than those appearing above. Unspecified.	277
ST	Student	1,129
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EMKEY, MD, KENNETH D GE
301 S 7TH AVE STE 215
WEST READING PA 19611-1450
610-374-4401

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WEST READING PA 19611-1124
610-375-4251

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425 E LANCASTER AVE
SHILLINGTON PA 19607-1363
610-777-7041

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WEST READING PA 19611-1450
610-374-4401

FALCONE, MD, PHILIP M OPH
WEST READING OPHTHALMIC
WEST READING PA 19611-1411
610-378-1344

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READING PA 19612-6052
610-378-6108

FARBER, MD, DAVID N OPH
1515 ALSACE RD
READING PA 19604-1659
610-374-5885

FARBER, MD, ERIC B OPH
606 COURT ST STE 200
READING PA 19601-3542
610-374-5885

FARBER, MD, HAROLD I IM
1511 HAMPDEN BLVD
READING PA 19604-1829
610-478-9131

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610-378-6067

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610-374-5000

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WEST READING PA 19611-1410
610-374-2214

FEICK, MD, RALPH H FP
WILLOW VALLEY ESTATES
WILLOW STREET PA 17584-9205

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290 RIDINGS WAY
BROAD AXE PA 19002-5246
610-378-5426

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200 N 13TH ST STE 304
READING PA 19604-2956
610-378-5200

FINCH, MD, FRANK G IM
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READING PA 19604
610-372-2351

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READING PA 19604-2956
610-376-3961

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READING PA 19604-2952
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2021 FRANKLIN PL
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WEST READING PA 19611-1410
610-374-2214

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WYOMISSING PA 19610-1698
610-678-4525

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1216 MEADE ST
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HIGHLANDS AT WYOMISSING
WYOMISSING PA 19610-2723
610-775-4471

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3351 PERKIOMEN AVE
READING PA 19606-2736
610-779-3500

GEYER, MD, DAVID W AN
1539 READING BLVD
WYOMISSING PA 19610-2443
610-376-6269

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12 BUCKINGHAM DR
READING PA 19605-1096
610-779-3330

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600 SCHUYLKILL AVE
READING PA 19601-2640
610-373-1616

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WYOMISSING PA 19610-2821
610-376-2230

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WYOMISSING PA 19610-1232
610-376-8691

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SHILLINGTON PA 19607
610-375-4542

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BIRDSBORO PA 19508
610-582-7637

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WYOMISSING PA 19610-2112

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120 VALLEY VIEW CIR
PHOENIXVILLE PA 19460-3185
610-376-2080

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404 ORCHARD VIEW LN
READING PA 19606-3214
610-378-2100

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20 MAPLE AVE
READING PA 19607-1216
610-376-2080

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239-A 14TH ST
READING PA 19604-2968
610-376-6000

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610-376-2100

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WEST READING PA 19611-1449
610-375-6226

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610-378-0107

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130 PROSPECT ST
READING PA 19606-2866
610-779-4786

GREENBERG, MD, ROBERT N GS
200 N 13TH ST STE 204
READING PA 19604-2955
610-376-6244

GREENE, MD, LUCILLE T * GP
412 N 12TH ST
READING PA 19604-2821
610-374-2435

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39 E LANCASTER AVE
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610-777-9883

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1235 PENN AVE
WYOMISSING PA 19610-2100
610-374-5000

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401 BUTTONWOOD ST
WEST READING PA 19611-1101
610-375-4251

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EXETER PEDIATRICS
READING PA 19606-9562
610-779-9550

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143 W PHILADELPHIA AVE
BOYERTOWN PA 19512-1429

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WEST READING PA 19611-1410
610-375-6565

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1848 READING BLVD
WYOMISSING PA 19610-2626
610-378-6108

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610-775-2799

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BETHLEHEM PA 18017-3937
610-372-0844

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145 N 6TH ST
READING PA 19604-1363
610-378-1900

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610-921-2094

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610-378-0353

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AND ASTHMA
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169 OAKMONT CT
READING PA 19607-3406

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3 PHEASANT LANE
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WEST READING PA 19611-1450
610-375-6565

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11A FLYING HILLS VILLAGE CTR
FLYING HILLS PA 19607
610-775-4500

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610-373-2544

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READING HOSP AND
MEDICAL CTR
READING PA 19612-6052
610-376-6088

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606 MUSEUM RD
READING PA 19611-1427
610-373-4007

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40 BERKSHIRE CT
WYOMISSING PA 19610
610-374-7400

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200 N 13TH ST STE 203
READING PA 19604
610-374-4616

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HAMBURG PA 19526-1510
610-562-4092

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READING PA 19603
610-376-2676

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READING PA 19612-6052

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WYOMISSING PA 19610-2722

IMBER, MD, IRVING IM
HIGHLANDS AT WYOMISSING
WYOMISSING PA 19610-2737
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IMPINK, MD, ROBERT R GS
125 ORCHARD PL
SHILLINGTON PA 19607-3226

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900 N 5TH ST
READING PA 19601-1602
610-375-1616

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560 VAN REED RD STE 102
WYOMISSING PA 19610-1799
610-372-0712

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4201 KUTZTOWN RD
TEMPLE PA 19560-1636
610-921-2094

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READING PA 19612-6052
610-376-6843

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1650 PENN AVE APT D
WYOMISSING PA 19610-2307
610-676-6851

JAXHEIMER, MD, ERIC C VS
801 S TRENT AVE
WYOMISSING PA 19610-2253
610-376-9667

JAY JR, MD, W THOMAS IM
516 LYNNE AVE
WYOMISSING PA 19610-2225

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345 GREEN BRIAR CT
WYOMISSING PA 19610-2730
610-777-7827

JIMERSON, MD, CEDRIC C GS
DORAL DR #7-B
READING PA 19607

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2240 PENN AVE
WEST LAWN PA 19609-1650
610-676-1140

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301 S 7TH AVE STE 365
WEST READING PA 19611-1436
610-373-5138

JOHNSON, MD, WILLIAM T * AN
170 WHITE HALL RD
REINHOLDS PA 17569-9549
610-376-6589

JONES JR, DO, ROBERT S ID
1320 FARR RD
READING PA 19611-1712
610-374-9523

KAO, MD, WINIFRED W OTO
301 S 7TH AVE STE 155
WEST READING PA 19611-1410
610-376-9726

KAPLAN, MD, LAWRENCE M DR
COMMUNITY GENERAL HOSPITAL
READING PA 19601-3501
610-373-3100

KAPLAN, MD, ROBIN L PUD
VP, MEDICAL AFFAIRS
READING PA 19603
610-376-2176

KAPLAN, MD, SHELDON J OPH
WEST READING
OPHTHALMIC ASSOC
WEST READING PA 19611-1411
610-376-1344

KARABELNIK, MD, DON FP
325 E LANCASTER AVE
SHILLINGTON PA 19607-2633
610-775-3316

KASE, MD, JAMES J IM
112 N 11TH ST
READING PA 19601-3707
610-376-9112

KASTENBAUM, MD, MICHAEL IM
101 W LANCASTER AVE
SHILLINGTON PA 19607-1657
610-777-6516

KEARNEY, MD, JOHN M GS
1130 SHELBOURNE RD
READING PA 19606-9771

KEFFER, MD, WILLIAM H OS
1424 MONROE AVE
WYOMISSING PA 19610-2436

KEISER, MD, E LEE GP
310 GRACE COMMUNITY
MYERSTOWN PA 17067-2208

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1334 GIRARD AVE
WYOMISSING PA 19610-2420

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KILCHEVSKY, MD, EITAN S * NPM
THE READING HOSP AND
MED CTR
READING PA 19612-6052
610-376-6843

KILLIAN III, MD, CALEB L * FP
2508 HAMPDEN BLVD
READING PA 19604-1009
610-921-3924

KIM, MD, CHUNG S * IM
140 W WINDSOR ST
READING PA 19601-2059
610-376-2230

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236 N 5TH ST
READING PA 19601-3325
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WEST READING PA 19611-1410
610-374-2214

KLOMBERS, MD, LEE A OPH
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WEST READING PA 19611-1411
610-376-1344

KNIAZER, MD, BARRY OBG
613 DAVIS RD
CHELTENHAM PA 19012-1636

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560 VAN REED RD
WYOMISSING PA 19610-1799
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KOHL, MD, STEPHEN D * OBG
640 WALNUT ST STE 301
READING PA 19601-3525
610-376-6668

KOREY JR, MD, JOSEPH J OBG
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READING PA 19604-2952
610-374-0970

KOVALSKY, MD, KENNETH FP
9 BRISTOL CT
WYOMISSING PA 19610-1605
610-670-2222

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403 N 13TH ST
READING PA 19606-9560
610-375-8577

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226 E WYOMISSING AVE
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232 PHEASANT RUN
LANSDALE PA 19446-5646

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3N VIA CASTILLA
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610-376-2100

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40 KENHORST BLVD
READING PA 19607
610-796-1000

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610-683-7115

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610-670-2280

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WEST READING PA 19611-1450
610-374-4404

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316 N 5TH ST
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610-376-5121

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610-775-4500

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610-374-9808

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MED CENTER
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ASSOC
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6 BALTRASER RD
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143 E WALL ST
LEESPORT PA 19533
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BOYERTOWN PA 19512-1008

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610-376-1900

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BLANDON PA 19510
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STEPHEN C ORS
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WEST READING PA 19611
610-376-8671

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READING PA 19605-2629
610-929-2762

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READING PA 19612-6052
610-376-6108

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WEST READING PA 19611-1410
610-374-4404

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222 N 12TH ST
READING PA 19604-2964
610-374-5599

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59 TIMBERLINE DR
READING PA 19610-1971
610-375-6565

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610-376-6000

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WEST READING PA 19611-1411
610-376-1344

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61 MEDINAH DR
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610-376-6269

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610-276-2080

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610-378-2330

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610-375-6147

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610-378-1900

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610-929-2433

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610-376-6269

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30 MATTHEW DR
SINKING SPRING PA 19608-9401
610-376-2080

MATTHEWS, MD, GEORGE R R
1310 MUSEUM RD
READING PA 19611-1439

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2660 HILL RD
READING PA 19606-9214
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610-777-7827

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701 E NEVERSINK RD
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610-779-7714

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READING PA 19604
610-378-2080

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PENNSIDE
READING PA 19606-1415
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301 S 7TH AVE STE 130
WEST READING PA 19611-1449
610-374-4421

MENGES JR, MD, JOB F ORS
1424 PENN AVE
READING PA 19610-2134
610-374-4474

MERCURIO, MD, TERESA ON
301 S 7TH AVE
WEST READING PA 19611-1410
610-374-4404

MEYERS, MD, JOHN L EM
320 4TH ST
SHILLINGTON PA 19607-2747

MILLER, MD, JAY B U
301 S 7TH AVE STE 340
WEST READING PA 19611-1451
610-375-4579

MINEHART, MD, CHARLES R CD
BERKS CARDIOLOGISTS LTD
READING PA 19604-2964
610-375-4679

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1917 STURBRIDGE DR
WYOMISSING PA 19610-2676
610-378-6269

MITNICK, MD, PAUL D NEP
301 S 7TH AVE
WEST READING PA 19611-1410
610-378-7365

MOFFITT, MD, VINCENT J PD
1258 PENN AVE
WYOMISSING PA 19610-2130
610-374-4491

MOLL, MD, THOMAS B OPH
VAN REED PROF BLDG
WYOMISSING PA 19610-1799
610-372-0712

MONDALA-OCBO, MD, ELISA V AN
4 SEVEN SPRINGS DR
READING PA 19607-9750
610-376-2459

MORGAN, MD, YVONNE G FP
ST JOSEPH FAMILY PRACTICE
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MORRISSEY JR, MD, E JAMES ORS
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MEDICAL OFFICE CENTER
READING PA 19604
610-378-5788

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610-373-3738

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610-376-8691

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200 N 13TH ST
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610-376-8244

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WOMELSDORF PA 19567-9801

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150 N 11TH ST
READING PA 19601-3707
610-373-6486

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MOHNTON PA 19540-9607

NASE, MD, P KENNETH OPH
WEST READING OPHTHALMIC
WEST READING PA 19611-1411

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WEST READING PA 19611-1124
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610-378-2330

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WEST READING PA 19611-1117
810-478-8662

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WYOMISSING PA 19610
810-375-4949

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610-376-6000

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2509 PERKIOMEN AVE
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610-375-8471

PADIYAR, MD, RAMDAS B AN
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810-376-2459

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WYOMISSING PA 19610-2820
610-375-6565

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610-375-4679

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MED CENTER
READING PA 19612-6052
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PARIKH, MD, SHIRISH N IM
73 S HAMPTON DR
WYOMISSING PA 19610-3108
610-376-4033

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2309 ALSACE RD
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159 VICTORIA LN
WYOMISSING PA 19610-1459

PAUL, MD, LEENA * AN
110 HEATHER LN
WYOMISSING PA 19610-1170
610-376-2459

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WEST READING PA 19608-9580
810-374-2214

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PELLECCHIA, MD, DENNIS J * AN
102 ROBERT RD
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610-378-6265

PELLEGRINI, MD, VINCENT A OBG
119 GAIL CIR
WYOMISSING PA 19610-3106
610-374-2214

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610-378-1658

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1711 READING BLVD
WYOMISSING PA 19610-2605
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SINKING SPRING PA 19608-9561
610-376-6269

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2601 MERRITT PKY
WEST LAWN PA 19609-1029

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610-375-4679

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245 ROSEDALE DR
POTTSTOWN PA 19464-4935

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1676 SHEVIDAN LN
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113 MEDINAH DR
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610-378-6198

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3625 STOUDTS FERRY
BRIDGE RD
READING PA 19605-1444
610-378-3936

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WEST READING PA 19611-1410
610-372-0813

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RTE 401
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610-374-5599

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MUHLENBERG MEDICAL ASSOC
TEMPLE PA 19560
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HAMBURG PA 19526-9519

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READING PA 19604-2116
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610-378-2330

ROBINSON, MD, MICHAEL L DR
60 DOWNING DR
WYOMISSING PA 19610-3109
610-378-6108

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WEST READING PA 19611-1410
610-374-2214

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WEST READING PA 19611-1410
610-378-5331

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301 S 7TH AVE STE 215
WEST READING PA 19611-1450
610-374-4401

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560 VAN REED RD STE 301
WYOMISSING PA 19610-1799
610-378-9601

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310 N 11TH ST
READING PA 19604-2904
610-373-1605

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READING PA 19612-6052
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READING PA 19603
610-376-2117

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855 N PARK RD APT CC 101
WYOMISSING PA 19610-1306
610-678-4552

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ST JOSEPH FAMILY PRACTICE
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610-378-2080

SANTORO, MD, WILLIAM * FP
3212 KUTZTOWN RD
READING PA 19605-2661
610-929-3380

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WEST LAWN PA 19609-2316
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READING PA 19601-2545
610-372-1614

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READING PA 19612-6052
610-276-6827

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ROBESONIA PA 19551-1527
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WEST READING PA 19611-1124
610-376-8671

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JOSEPH M U
111 CLUBHOUSE DR
BERNVILLE PA 19506-9536

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WYOMISSING PA 19610-1607
610-478-1737

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1219 WEAVERTOWN RD
DOUGLASSVILLE PA 19516-6601

SEDA, MD, HECTOR J HNS
301 S 7TH AVE
WEST READING PA 19611-1410
610-376-9726

SEO, MD, JIN S AN
BERKS ANESTHESIA ASSOC INC
READING PA 19604-2991
610-376-2459

SERGI, MD, MICHAEL A PD
40 BERKSHIRE CT
READING PA 19610-1224
810-374-7400

SERGI, MD, TIFFANY L PD
40 BERKSHIRE CT
WYOMISSING PA 19610
610-374-7400

SEXTON JR, MD, GEORGE L GYN
301 S 7TH AVE
WEST READING PA 19611-1410
810-374-2214

SHADDUCK, MD, SNEED P AN
READING HOSPITAL &
MED CENTER
READING PA 19612-6052
610-378-6269

SHAFFER, MD, EUGENE M GS
301 S 7TH AVE STE 310
WEST READING PA 19611-1451
610-378-7900

SHAFFER, MD, IRVIN G AN
2200 LORRAINE RD
READING PA 19604-1304

SHAH, MD, HARNISH V PD
501 WARWICK DR
READING PA 19610-1625
610-921-1111

SHAPIRO, MD, JOHN A PUD
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
610-374-4421

SHEFFER, MD, M LEONARD * GP
310 FAIRVIEW CHAPEL RD
BIRDSBORO PA 19508-6816
810-582-2848

SHEMANSKI, MD, CLEM J GER
PHOEBE BERKS VILLAGE
READING PA 19565

SHIPPEN, MD, EUGENE R GP
9 E LANCASTER AVE
SHILLINGTON PA 19607-2631
610-777-7896

SHULTZ, MD, BARRY S U
301 S 7TH AVE STE 340
WEST READING PA 19611-1451
610-375-4579

SHUMAN, MD, JOHN F PUD
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
610-374-4421

SHUMAN, MD, NANCY A IM
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
610-374-4422

SILVERMAN, MD, EDWARD J IM
600 MUSEUM RD
READING PA 19611
810-375-0260

SKORPINSKI, MD, EDWARD W PD
40 BERKSHIRE CT
WYOMISSING PA 19610
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SLAVISH, MD, LYDIA G * OBG
CENTER FOR WOMANS
HEALTHCARE
EXTON PA 19341
610-594-0850

SMITH, MD, BARTON L GE
301 S 7TH AVE
WEST READING PA 19611-1410
610-374-4401

SMITH, MD, RAYMOND L PS
928 PENN AVE
WYOMISSING PA 19610-3017
810-372-2130

SMITH, MD, RONALD E AN
960 WAYNE AVE
WYOMISSING PA 19610-2272
610-376-6269

SOFFER, MD, STEPHEN R ORS
2201 RIDGEWOOD RD
WYOMISSING PA 19610-1189
610-375-4949

SOUDERS, MD, THOMAS B * OPH
VAN REED PROF BLDG
WYOMISSING PA 19610-1799
610-372-0712

STAEBLER, MD, ROBIN J * FP
2948 ST LAWRENCE AVE
READING PA 19606-2233
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STANTON, MD, ELIZABETH L FP
412 SYCAMORE RD
WEST READING PA 19611-1540
610-378-2080

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610-376-1900

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1715 ALSACE RD
READING PA 19604-1625
610-375-8471

STELMACH, MD, PAUL * PUD
1940 N 13TH ST
READING PA 19604
610-929-2433

STELMACH, MD, PETER IM
1500 OAK LN
READING PA 19604-1868
810-373-7833

STELMACH, MD, W PETER FP
1500 OAK LN
READING PA 19604-1895
610-373-7833

STOLZ, MD, JOHN C R
THE HIGHLANDS APT 117
READING PA 19610-2714

STOLZ, MD, JONATHAN L R
COMMUNITY GENERAL HOSPITAL
READING PA 19601-3501
610-378-2100

STOLZ, MD, PAUL K R
39 SHEEP HILL RD
FLEETWOOD PA 19522-9609

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801 SLEDGE AVE
READING PA 19609-1112

STOUDT, DO, KATHY J FP
711 N 5TH ST
READING PA 19601-2209
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STRAUSE JR, MD, HAROLD L OPH
289 LEVAN ST
READING PA 19606-2808

STROBEL JR, MD, GEORGE E * AN
RR 1 BOX 106
WERNERSVILLE PA 19565-9722
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SINKING SPRING PA 19608

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810-378-2080

SUTHERLAND, MD, ROBERT D ORS
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WEST READING PA 19611-1124
610-376-8671

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RR 1 BOX 200
OLEY PA 19547-9606
610-378-6269

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READING PA 19612-6052
610-376-6067

TALLMAN, MD, EDWIN H GP
27 ST PAULIA LANE
OLEY PA 19547-9734

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200 N 13TH ST STE 100
READING PA 19606-1255
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READING PA 19606
610-375-8471

TIETBOHL, MD, RALPH H FP
25 STEVENS AVE
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610-676-2266

TOSO, MD, GIANFRANCO F OTO
301 S 7TH AVE
WEST READING PA 19611-1410
610-378-9726

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PHOEBE BERKS VILLAGE
WERNERSVILLE PA 19565-2019

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610-376-2080

TRUEX JR, MD, RAYMOND C NS
601 SPRUCE ST
WEST READING PA 19611-1443
610-375-4567

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357 PENNSYLVANIA AVE
SHILLINGTON PA 19607-1313

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READING PA 19604-2956
610-372-5196

VILLARS, MD, FREDERICK CDS
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401 BUTTONWOOD ST
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111 LUCINDA LANE
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640 WALNUT ST
READING PA 19601-3525
610-372-3824

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1212 LIGGETT AVE
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1801 CAMBRIDGE AVE APT A1
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1907 MEADOW LN
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560 VAN REED RD
WYOMISSING PA 19610-1799
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63 DOWNING DR
WYOMISSING PA 19610-3111
610-378-6108

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READING PA 19603
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READING PA 19607
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READING PA 19604-2955
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READING PA 19604-2822
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READING PA 19601-2212
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READING PA 19607
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MED CENTER
READING PA 19612-6052
810-378-6067

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TEMPLE PA 19560-1838
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READING PA 19611-1206

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WEST READING PA 19611-1450
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WEST READING OPHTHALMIC
WEST READING PA 19611-1411
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215-757-5800
GITTLEN, MD, STANFORD D * PUD
800 W STATE ST STE 204
DOYLESTOWN PA 18901-5842
215-348-1310
GODSHALL, MD, RICHARD W ORS
PROF CENTER
SELLERSVILLE PA 18960-1575
215-257-3700
GOLD, MD, JONATHAN * CD
ST MARY HOSPITAL MOB
LANGHORNE PA 19047
215-750-7818
GOLDBERG, MD, HARVEY E IM
401 RADCLIFFE ST
BRISTOL PA 19007-5126
215-785-6531
GOLDBERG, MD, MICHAEL E * AN
80 POST RD
CHURCHVILLE PA 18966-1160
609-393-6868
GOLDFARB, MD, RICHARD M * GS
9 BAYSHORE DR
NEWTOWN PA 18940-3805
215-741-4321
GOLDSTEIN, MD, ARNOLD L * IM
170 MIDDLETOWN BLVD STE 101
LANGHORNE PA 19047-1822
215-757-8100
GOLDSTEIN, MD, RICHARD S CRS
390 MIDDLETOWN BLVD STE 612
LANGHORNE PA 19047-1822
215-741-4910
GONZALES, MD, ALBERT FP
103 WESTFIELD RD
SHELBY NC 28150-4838
GOODMAN, MD, BRUCE A * IM
8 SNOWDROP PLACE
NEWTOWN PA 18940
215-598-3830
GOODMAN, MD, MICHAEL S U
205 NEWTOWN RD STE 213
WARMINSTER PA 18974-5207
215-674-9133
GORDON, MD, GREGORY R FP
333 N OXFORD VLY RD RM 201
FAIRLESS HLS PA 19030
215-946-1500
GORDON, MD, RICHARD D RHU
380 MIDDLETOWN BLVD STE 704
LANGHORNE PA 19047-1822
215-757-5665
GOTTLIEB, DO, MARK S FP
20 HEIGHTS LN
FEASTERVILLE PA 19053
215-355-3636

GREEN, MD, BRADFORD OBG
BOX 81
ROYAL OAK MD 21662
GREENBAUM, MD, ROY L DR
43 POLDER DR
LANGHORNE PA 19053-1521
609-585-8800
GREENSPAN, MD, MITCHELL M * CD
3 LIFEMARK DR
SELLERVILLE PA 18960
215-257-1127
GRESS, MD, JEFFREY P * CD
303 W STATE ST
DOYLESTOWN PA 18901
215-345-1990
GRIBB, MD, JOHN J OBG
14A MEMORIAL DR
DOYLESTOWN PA 18901
348-205-0
GRIFFITH, MD, ANNETTE Y DR
ABINGTON MEMORIAL HOSPITAL
ABINGTON PA 19001-3788
215-947-7851
GRUZIN, DO, RONALD IM
4642 HILLSIDE AVE
BENSALEM PA 19020-1103
215-949-5000
GUAGLIARDO, DO, JOSEPH P ORS
253 W STATE ST
DOYLESTOWN PA 18901-3531
215-348-0222
GUPTA, MD, NAND K GP
3618 CLEAR SPRINGS DR
BENSALEM PA 19020-4702
215-639-7363
GUSA JR, MD, WILLIAM E AN
42 PILGRIM DR
TOLLAND CT 06084
GUTOWICZ, MD, LORRAINE F OM
3930 NETHERFIELD RD
PHILADELPHIA PA 19129-1014
215-291-3059
GUTTMAN, MD, MICHAEL IM
2793 MECHANICSVILLE RD
BENSALEM PA 19020-2626
215-752-5501
HAAS, DO, GLENN E VS
74 MISTY MEADOW DR
RICHBORO PA 18954-1643
215-295-6222
HAIMOWITZ, MD, DANIEL IM
1098 COUNTRY HILLS ROAD
YARDLEY PA 19067-6025
215-943-2222
HALE, MD, ROBERT H IM
14B MEMORIAL DR
DOYLESTOWN PA 18901
215-345-6050
HALPERN, MD, JANIS S PD
2060 DAWN LANE
NEWTOWN PA 18940-3738
215-752-8700
HAMMOD, MD, RIYADH S IM
406 C9 NEWGATE COURT
ANDALUSIA PA 19020
215-893-2000
HANNUSH, MD, SADEER B OPH
400 MIDDLETOWN BLVD STE 110
LANGHORNE PA 19047-5738
215-752-8564
HANSEN, MD, CARL A ORS
711 LAWN AVE PROF CTR
SELLERSVILLE PA 18960
215-257-3700
HARDY, MD, CHARLES A AN
862 GAINSWAY RD
YARDLEY PA 19067-3009
215-750-6800
HARR, MD, DOUGLAS P IM
836 LAWN AVE
SELLERSVILLE PA 18960-1550
215-257-3011
HARRISON, MD, BERNARD M FP
NESHAMINY MANOR HOME
DOYLESTOWN PA 18901
215-345-3205
HARRISON, MD, BRETT M GS
FRANKLIN AND WOOD ST
DOYLESTOWN PA 18901
215-348-7080
HARTENBAUM, MD, DAVID OPH
1600 WHITEHOUSE RD
MAPLE GLEN PA 19002-3121
HARTENBAUM, MD, NATALIE P OM
1600 WHITEHOUSE RD
MAPLE GLEN PA 19002-3121
215-652-7019
HASIUK, MD, AARON S OBG
1310 FROSTY HOLLOW RD
LEVITTOWN PA 19056-2404
215-943-3300
HAYMAN, MD, HARRY B OBG
15 GREAT OAKS ROAD
NEW HOPE PA 18938-1108
215-946-2682
HEDRICK, MD, G WINFIELD FP
24 FOXGLOVE CT
DOYLESTOWN PA 18901-2644
HEINE, MD, MARILYN J * IM
900 TWINING RD
DRESHER PA 19025-1728
215-785-9400

HELZNER, MD, EILEEN C GP
505 ANTHONY DR
PLYMOUTH MTNG PA 19462-1043
215-233-7786
HERMANN, MD,
CHRISTOPHER P * IM
301 S MAIN ST STE 2
DOYLESTOWN PA 18901-4870
215-348-4800
HERMANY, MD, PAUL R CD
PO BOX 186
HILLTOWN PA 18927-0186
215-257-1127
HIDALGO, MD, HORACIO A FP
1 SUGARMAPLE LN
LEVITTOWN PA 19055-2007
215-945-6500
HIDALGO JR, MD, HORACIO A FP
1 SUGARMAPLE LN
LEVITTOWN PA 19055-2007
215-945-6500
HIGHTOWER, MD, MARTIN C RO
1303 TYLER WAY
LANSDALE PA 19446-4445
215-453-4000
HIPP, MD, THOMAS J PD
711 LAWN AVE
SELLERSVILLE PA 18960-1575
215-257-2727
HIRSCH, DO, WILLIAM S IM
658 ALDER CT
YARDLEY PA 19067-6335
HOLLAND-HULL, MD, NORMAN E P
73 ROCKRIDGE ROAD
UPPER BLACK EDDY PA 18972-9559
215-897-8563
HOLLANDER, MD, IRWIN J * PTH
GRAND VIEW HOSPITAL
SELLERSVILLE PA 18960
215-453-4522
HOLTZMAN, MD, HENRY B * IM
800 W STATE ST
DOYLESTOWN PA 18901-2250
215-348-1310
HORWITZ, MD, MILTON R OTO
103 PROGRESS DR
DOYLESTOWN PA 19446-1083
215-348-1152
HOUGAARD, MD, JOHN P GP
800 TRENTON ROAD
LANGHORNE PA 19047-5699
HOWELL, MD, JOHN T FP
62 S MAIN ST
YARDLEY PA 19067-1511
215-493-5535
HUNT, MD, EUGENE H DR
DOYLESTOWN HOSPITAL
DOYLESTOWN PA 18901
215-345-2174
HUNTER, MD, MARVIN T PS
301 S MAIN ST STE 2-3 SOUTH
DOYLESTOWN PA 18901-4870
215-672-0700
HUTCHINGS, MD, DIANA M DR
3538 AQUETONG RD
CARVERSVILLE PA 18913-9700
215-453-4514
IANNOTTA, MD, PATRICIA N D
475 NORTH ST
DOYLESTOWN PA 18901-3865
215-348-0717
IRWIN, MD, JOHN T * ORS
680 HEACOCK RD STE 201
YARDLEY PA 19067-6346
215-321-9520
JACOBELLI, MD, MICHAEL C GS
ST MARY MEDICAL BLDG STE 400
LONGHORNE PA 19047
215-757-6400
JAFFE, MD, JOEL D * OTO
400 MIDDLETOWN BLVD STE 100
LANGHORNE PA 19047-1822
215-757-7300
JAFFE, MD, STEPHEN C R
1548 RIVER RD
NEW HOPE PA 18938-9287
215-322-8320
JAKABOVICS, MD, EVA PD
33 LENAPE RD
RICHBORO PA 18954-1219
JANNELLI, MD, ANGELA F RHU
1723 WOODBOURNE RD
LEVITTOWN PA 19057-5205
215-945-1313
JARMAN, MD, MARTHA L GP
981 2ND ST PIKE
RICHBORO PA 18954-1526
215-357-3533
JAVIAN JR, MD, THOMAS A ORS
ST MARY MED BLDG STE 301
LANGHORNE PA 19047
215-752-8228
JENNINGS, MD, JOHN F HS
STONERIDGE PROFESSIONAL CTR
SELLERSVILLE PA 18960
215-257-6898
JUNG, MD, JENNIFER L AN
700 LAWN AVE
SELLERSVILLE PA 18960-1548
215-453-4810
JUNOD, MD, JOHN B FP
350 S MAIN ST STE 215
DOYLESTOWN PA 18901-4873
215-348-4914

KAJI, MD, VIKRAM H OBG
69 S MAIN ST
YARDLEY PA 19067-1510
215-493-4800
KALCHMAN, MD, STEVEN H R
LOWER BUCKS HOSPITAL
BRISTOL PA 19007
215-785-9333
KARNIK, MD, SUBASH S GS
205 NEWTOWN RD STE 215
WARMINSTER PA 18974-5207
215-672-6509
KASIRSKY, DO, GILBERT GP
66 BUCK RD
HOLLAND PA 18966-1705
215-322-2444
KAUFMAN, MD, ALAN C * ON
920 LAWN AVE
SELLERSVILLE PA 18054
215-257-8858
KENNEDY, DO, JULIA M IM
1680 FRANKLYNN DRIVE
FURLONG PA 18925-1441
215-969-8949
KENNEDY, MD, THOMAS I PD
PENRIDGE PEDIATRIC ASSOC
SELLERSVILLE PA 18960-1583
215-257-2727
KETELS, MD, ERK A OBS
259 CLUB HOUSE DR
WILLINGBORO NJ 08046-3522
KHAN, MD, ZAHID T US
2517 DUNKS FERRY RD APT B201
BENSALEM PA 19020-2711
215-831-2143
KIM, MD, IN-SOON FP
801 W TRENTON AVE
MORRISVILLE PA 19067-3518
215-736-9500
KIM, MD, YOUNG W * AN
36 SUTPHIN RD
YARDLEY PA 19067-3450
KIM, MD, YUNG S IM
1532 PARK AVE
QUAKERTOWN PA 18951-1815
215-536-7185
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PO BOX 72
SELLERSVILLE PA 18960-0072
KLEEMAN, MD, AUDREY K IM
825 TOWN CENTER DR STE 150
LANGHORNE PA 19047-1752
215-752-8700
KMETZO, MD, JAMES J * CD
303 W STATE ST
DOYLESTOWN PA 18901-3559
215-345-1900
KNAPP, MD, MICHAEL A IM
205 NEWTOWN RD STE 219
WARMINSTER PA 18974-5207
215-672-4726
KNAPP, DO, STEPHANIE A A
221 WESTWIND WAY
DRESHER PA 19025-1419
KNOUSE, MD, ALBERT B FP
1 SUGARMAPLE LN
LEVITTOWN PA 19055-2007
215-945-6500
KOEHLER, MD, WILLIAM P FP
350 S MAIN ST
DOYLESTOWN PA 18901
215-348-4914
KOELSCH, MD, ROBERT R D
712 LAWN AVE
SELLERSVILLE PA 18960-1548
KOLBER, MD, LAUREN R D
MALLARD CREEK VILLAGE
RICHBORO PA 18964
215-357-7303
KONCHANIN, MD, LYNN M PD
370 MIDDLETOWN BLVD STE 502
LANGHORNE PA 19047-1840
215-741-0336
KOWALYSHYN, MD, MICHAEL J PTH
415 SOLLY AVE APT C5
PHILADELPHIA PA 19111-1882
215-785-9307
KRAJESKI, MD, R DREW ORS
1205 LANGHORNE NEWTOWN RD
LANGHORNE PA 19047-1223
215-750-0220
KRATZ, MD, VERNON H P
PENN FOUNDATION
SELLERSVILLE PA 18960
215-257-6551
KRICK, MD, ANDREW E IM
275 S MAIN ST STE 6
DOYLESTOWN PA 18901
215-348-3990
KRIEBEL, MD, RICHARD H AN
151 KNAPP RD
LANSDALE PA 19446-1731
KROPINICKI, MD, WILLIAM C IM
699 DOLORO DR
MORRISVILLE PA 19067-6809
215-736-8708
KUCER, MD, FRANK T GE
817 LAWN AVE
SELLERSVILLE PA 18960-1549
215-257-5071
KUCER, MD, KATHLEEN A D
817 LAWN AVE
SELLERSVILLE PA 19436-0317
215-257-0196

KUHN, MD, MARK D OBG
2222 TRENTON RD
LEVITTOWN PA 19056-1421
215-547-0505
KUPERSMITH, MD, STEPHEN J OBG
670 LAWN AVE
SELLERSVILLE PA 18960-1571
KUTNER, MD, BARRY N * OPH
301 OXFORD VALLEY RD
STE 801A
YARDLEY PA 19067
215-493-7330
LANDES, MD, RAY P IM
35 W RELIANCE RD
SOUDERTON PA 18964-1637
LANE, MD, BARBARA PD
117 BARBERRY CT
CHALFONT PA 18914-2133
215-723-7177
LANE, MD, JOHN D FP
833 DURHAM RD
PENNDEL PA 19047-5736
215-752-5433
LAUANDOS, MD, IBRAHIM E * PS
1 E DEEP DALE DR
LEVITTOWN PA 19056-1004
215-945-3737
LAUDENSLAGER, MD, ELMER C GP
272 W COURT ST
DOYLESTOWN PA 18901-4043
LAVIN-LESKA, MD, LINDA S PTH
GRANDVIEW HOSPITAL
DEPT PTH
SELLERSVILLE PA 18960-1581
215-453-4523
LAVRICH, MD, JUDITH B OPH
1568 WOODBOURNE RD
LEVITTOWN PA 19057
215-943-7800
LEAHY, MD, JOANN M RO
307 PLEASANT ACRE DR
AMBLER PA 19002-4276
810-543-4950
LECAVALIER, MD, LARRY A DR
921 LANYARD RD
YARDLEY PA 19067-3013
809-393-0333
LEDIS, MD, SEYMOUR PD
370 MIDDLETOWN BLVD STE 502
LANGHORNE PA 19047-1840
215-741-0336
LEE, MD, CHANCHI U
2230 OXFORD VALLEY RD
LEVITTOWN PA 19057-1303
215-945-4640
LEE, MD, HOWARD J PUD
1205 LANGHORNE-NEWTOWN RD
LANGHORNE PA 19047
215-757-1414
LEIBY, MD, DAVID K GP
777 FERRY RD APT 447
DOYLESTOWN PA 18901-2102
LEISTER, MD, HOWARD A FP
400 WASHINGTON AVE
NEWTOWN PA 18940-2130
215-968-2187
LEVENTHAL, MD, LINDA C D
660 KORISA DR
HUNTINDGON VLY PA 19006-2224
215-752-7500
LEVIN, MD, GENE D ORS
71 E ASHLAND ST
DOYLESTOWN PA 18901-4631
215-348-2223
LEVIN, MD, LARRY L IM
503 WARMINSTER RD APT 8
HATBORO PA 19040
215-355-4036
LEVIN, MD, MOISEY N
70 SNOWFLAKE RD
HUNTINGDON VLY PA 19006-1527
LEVIN, DO, MORRIS DR
UPPER BUCKS
RADIOLOGY ASSOC
SELLERSVILLE PA 18960-0168
215-538-4610
LEVIN, MD, RICHARD L DMP
9824 N 53RD PL
SCOTTSDALE AZ 85253
LEVY, MD, SCOTT S IM
3655 ROUTE 2020 STE 205
DOYLESTOWN PA 18901-2503
215-348-8020
LEWIS, MD, PHILIP G * GPM
ROHN AND HAAS CO
BRISTOL PA 19007
215-785-7421
LIEBERMAN, MD, BRUCE L * FP
200 POPLAR RD
CHALFONT PA 18914-2123
215-822-3113
LIEBMAN, MD, IRVIN M D
59 PINEWOOD DR
LEVITTOWN PA 19054-3607
215-945-2555
LIEBREICH, MD, MARK FP
333 N OXFORD VALLEY RD 201
FAIRLESS HLS PA 19030
215-946-1500
LINDBERG, MD, NICHOLAS O OBG
34 HILLENDALE RD
PERKASIE PA 18944-2368
215-257-0414

LIPES, MD, JAN K OS
RR 2
DOYLESTOWN PA 18901-9802
215-794-3308

LIPSON, MD, M BARRY * ORS
505 WASHINGTON AVE
NEWTOWN PA 18940-2144
215-986-6774

LITOVSKY, MD, DANIEL A IM
1723 WOODBOURNE RD
LEVITTOWN PA 19057-5205
215-945-1650

LOEV, MD, MARVIN OBG
1339 WOODBOURNE RD
LEVITTOWN PA 19057-1236
215-945-6700

LOREMAN, DO, LORIE IM
27 1/2 PRISCILLA RD 1ST FLR
BRIGHTON MA 02135-4006

LOUGHRAN, DO, DAVID H * ID
50 OPAL CT
NEWTOWN PA 18940-2434
215-581-9666

LOUX, MD, NORMAN L P
PENN FOUND FOR MEN HLTH
SELLERSVILLE PA 18960-0032
215-723-2060

LUDWICK, MD, DAVID J * OPH
638 NEWTOWN-YARDLEY RD
NEWTOWN PA 18940
215-860-0909

LUSCOMBE, MD, HERBERT J FP
1400 NEW RODGERS RD 107
LEVITTOWN PA 19058
215-752-4433

LYONS, MD, DANIEL C GER
PO BOX 948
HORSHAM PA 19044-0946
215-442-2805

LYONS, MD, WILBERT A P
333 S 3RD ST
PERKASIE PA 18944-1817
215-443-4411

MACKELL, MD, THOMAS E * ORS
800 W STATE ST STE 202
DOYLESTOWN PA 18901-5842
215-348-3938

MADANY, MD, BAHIJ H U
919 DURHAM RD
PENNDEL PA 19047-5738
215-752-2260

MADDEN, MD, FRANCIS P IM
5 MERRYDELL DR
CHURCHVILLE PA 18966
215-322-1899

MADDEN, MD, ROBERT A * IM
3554 HULMEVILLE RD STE 106
BENSALEM PA 19020-4312
215-245-4006

MAHAN, MD, JOHN P IM
1205 LANGHORNE-NEWTON RD
LANGHORNE PA 19047
215-757-1414

MALTA, DO, RAYMOND J EM
506 B-3 HARBOUR DR
ANDALUSIA PA 19020
609-246-6000

MANNARINO, MD, ANTHONY P OPH
103 MILL ST
BRISTOL PA 19007-4806
215-781-2020

MARCHANT, MD, ERIC A PS
708 SHADY RETREAT RD STE 502
DOYLESTOWN PA 18901-2503
215-230-0400

MARCIANO, MD, JULIET A PD
9110 AYRDALE CRESCENT
PHIALDELPHIA PA 19128-1049
215-257-2727

MARCOUX, MD, ANNE-MARIE C CRS
390 MIDDLETOWN BLVD STE 612
LANGHORNE PA 19047-1822
215-741-4910

MARFATIA, MD, SUDHIR K CD
205 NEWTOWN RD STE 217
WARMINSTER PA 18974-5207
215-441-0931

MARFATIA, MD, USHA S ON
205 NEWTOWN RD STE 217
WARMINSTER PA 18974-5207
215-441-0931

MARIOTTI, MD, RITA A FP
163 S GLASSBORO RD
WOODBURY NJ 08097
609-845-9212

MARKOS, MD, RONALD P GE
737 KNIGHT RD
PENLLYN PA 19422-1149
215-257-5071

MARKOW, MD, HARRY G CHP
87 WOODEN BRIDGE RD
HOLLAND PA 18966-2249
215-968-1777

MARLAPUDI, MD, PREM K NPM
86 HIDDEN TURN
NEWTOWN PA 18940-1127
215-750-5990

MARTIN, MD, CHERYL A FP
PO BOX 21037
PHILADELPHIA PA 19114-0537

MARTYNEC, MD, BOHDAN IM
708 N SHADY RETREAT RD
DOYLESTOWN PA 18901-2503
215-348-4478

MATARESE, MD, EMIL L N
ST MARY MEDICAL BUILDING
LANGHORNE PA 19047
215-741-9555

MATLACK, MD, EILEEN O AN
884 PATRIOT DR
YARDLEY PA 19067-4379
215-750-2196

MAXIAN, DO, JOSEPH A * FP
58 HIGHLAND PARK WAY
LEVITTOWN PA 19056-1158
215-945-0707

MAZAHERI, MD, AHMED U
285 CHERRY LN
DOYLESTOWN PA 18901-3112
215-348-5665

MAZICH, MD, THERESA E D
30 CITADEL CIR
CHALFONT PA 18914-2256
215-340-0440

MAZLIN, MD, STEVEN E N
ST MARY MEDICAL BUILDING
LANGHORNE PA 19047
215-741-9555

MC GARRY, MD, THOMAS F CD
340 AQUETONG RD
NEW HOPE PA 18938-1107
215-338-4777

MC GARVEY, MD, EILEEN F * TR
801 NEW CHESTNUT ST
BRISTOL PA 19007-6452
215-728-2406

MC GARVEY, MD, JOSEPH F CD
14B MEMORIAL DR
DOYLESTOWN PA 18901-3511
215-345-6050

MC ILVAINE, MD, PAUL W * FP
218 MULBERRY ST
BRISTOL PA 19007-4909
215-788-1007

MC LOUGHLIN, MD, PATRICK T FP
1071 MT EYRE RD
WASHINGTON CROSSING PA 18977-1502
215-968-5814

MEARS, MD, ELMER E GP
1 POST LN
LEVITTOWN PA 19054-3613
215-946-4687

MENACKER, MD, SHERYL J OPH
191 SAVAGE DR
HOLLAND PA 18966-2258
215-757-6200

MENNA, MD, VINCENT J * PD
708 N SHADY RETREAT RD
DOYLESTOWN PA 18901-2503
215-345-6090

MERSKY, MD, MARTIN R IM
825 TOWN CENTER DR STE 150
LANGHORNE PA 19047-1752
215-752-8700

METKUS, MD, FRANCIS M IM
1511 BROCK CREEK DR
YARDLEY PA 19067-5604
215-945-1650

MILAZZO, MD, JOHN V ON
750 S WEST END BLVD
QUAKERTOWN PA 18951-2662
215-536-1133

MILLER, MD, BRIAN A OTO
400 MIDDLETOWN BLVD STE 100
LANGHORNE PA 19047-1822
215-757-7300

MILLER, MD, DAVID H OPH
319 2ND STREET PIKE
SOUTHAMPTON PA 18966-3865
215-355-4428

MILLER, MD, LEE H OTO
400 MIDDLETOWN BLVD STE 100
LANGHORNE PA 19047-1822
215-757-7300

MILLER, MD, ROBERT W DR
4121 FIELDCREST CT
LAWRENCEVILLE NJ 08648

MILLS, MD, WILLIAM L R
3726 WINDY BUSH RD
NEW HOPE PA 18938-9308

MINO, MD, DAVID E * ORS
1400 NEW RODGERS RD
LEVITTOWN PA 19056-2115
215-752-4000

MIRSKY, MD, ROBERT S IM
401 RADCLIFFE ST
BRISTOL PA 19007-5126
215-785-6531

MOGUL, MD, ROBERT IM
524 CEDAR HOLLOW DR
YARDLEY PA 19067-6356

MOLL, MD, DAVID C FP
1301 N 5TH ST
PERKASIE PA 18944-2256
215-257-5128

MONKOWSKI, MD, ALFRED M * IM
33 S DELAWARE AVE STE 104
YARDLEY PA 19067-4307
215-321-0966

MOORE, MD, DANIEL W NS
101 MECHANICS ST
DOYLESTOWN PA 18901-3753
215-340-0300

MOSES, MD, BRETT L OTO
400 MIDDLETOWN BLVD STE 100
LANGHORNE PA 19047
215-757-7300

MOYER, MD, DENNIS L GS
131 FAIRHILL RD
HATFIELD PA 19440-1139
215-257-3697

MOYER, MD, JOHN P CD
3 LIFE MARK DRIVE
SELLERSVILLE PA 18960
215-257-1127

MOYER, MD, PAUL R GER
3435 BRISTOL RD
CHALFONT PA 18914-3821
215-343-4388

MUFSON, MD, RICHARD A P
712 OLD ORCHARD LN
BRISTOL PA 19007-6410
215-785-1232

MULLIN JR, MD, HUGH J R
330 MIDDLETOWN BLVD STE 402
LANGHORNE PA 19047-1822

MUNLEY, MD, BRIAN J CD
14B MEMORIAL DR
DOYLESTOWN PA 18901
215-345-6050

MURRAY, DO, MICHAEL L * GP
592 HEATONS MILL DR
LANGHORNE PA 19047-1519
215-737-2551

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708 N SHADY RETREAT RD STE 8
DOYLESTOWN PA 18901-2503
215-348-4577

MYERS, MD, PHILIP A IM
275 S MAIN ST
DOYLESTOWN PA 18901-4815
215-348-3990

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JUNO BEACH FL 33408-2174

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WEST CHESTER PA 19382-7659
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BRANDYWINE PROF BLDG
COATESVILLE PA 19320-1531
610-384-5110

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415 E LINCOLN HWY
COATESVILLE PA 19320-3411
610-383-1955

GOLDFINE, MD, ALAN OBG
1601 ROBIN RD
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610-383-7800

GOLDSTEIN, MD, NEIL H IM
346 S BALDERSTON DR
EXTON PA 19341-2004
215-983-6657

GOLDSTEIN, MD, NORMAN A * OTO
206 GAY ST
PHOENIXVILLE PA 19460-2705
610-933-6696

GORDON, MD, ISADORE IM
603 S MAIN ST
PHOENIXVILLE PA 19460-3621

GORMAN-CATTON, MD,
JOHANNA H * P
45 RIDGE RD
PHOENIXVILLE PA 19460-1915
610-933-7749

GRAHAM, MD, THOMAS H * N
4 JOANNA DR
MALVERN PA 19355-3313
610-527-3366

GRANT, MD, HOWARD R PD
533 SCOTT RD
GLADWYNE PA 19035-1441
610-431-5460

GROSSMAN, MD, DAVID HEM
520 MAPLE AVE STE 1
WEST CHESTER PA 19360
610-692-5217

GUNNING, MD, MARY LISA FP
1308 FIELDPOINT DR
WEST CHESTER PA 19382-6229
610-696-6655

HAHN, MD, JEANNINE R * IM
BUCKTOWN MEDICAL ASSOC
SPRING CITY PA 19475-9685
610-495-5944

HALL, MD, EDGAR M IM
7 ROBINS LN
BERWYN PA 19312-1229

HANNA, MD, ROBERT H GP
7 PROUT DR
COATESVILLE PA 19320-1424

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1011 W BALTIMORE PIKE STE 210
WEST GROVE PA 19390-9402
610-869-3933

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1011 SABER RD
WEST CHESTER PA 19382-6071

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1330 THOMAS RD
WAYNE PA 19087-1316
610-644-9233

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23 BROOKMEAD RD
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POTTSTOWN PA 19484-7520
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1740 LEWAPE RD
WEST CHESTER PA 19382-6916

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WEST CHESTER PA 19380-2320

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PAOLI PA 19301
610-647-8885

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203 BARNHILL RD
WEST CHESTER PA 19382-2334
610-869-1000

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KENNETT SQUARE PA 19348-3504
610-444-5676

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WEST CHESTER PA 19382-4676
610-692-8100

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3025 ZINN RD
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PO BOX 400
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610-255-4466

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1288 VALLEY FORGE ROAD
VALLEY FORGE PA 19482
610-983-9299

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617 KIMBERLY LN
WEST CHESTER PA 19382-7107
215-662-4000

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WEST CHESTER PA 19380-4446
610-692-5582

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845 W CHESTER PIKE
WEST CHESTER PA 19362-4676
610-692-2005

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200 E BIDDLE ST
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213 REECEVILLE RD STE 13
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THORNDALE PA 19372-1129
610-383-1100

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WEST CHESTER PA 19382-4676
610-692-8100

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610-384-1801

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610-363-7244

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1138 DORSET DR
WEST CHESTER PA 19382-6006
610-431-2691

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WILLOWDALE PROF BLDG STE 2
KENNETT SQUARE PA 19346-1736
610-444-0113

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PAOLI MEM MED BLDG STE 109
PAOLI PA 19301
610-265-1188

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PAOLI PA 19301
610-647-4260

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101 MANOR AVE
DOWNINGTOWN PA 19335-2601
610-269-4449

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1438 POTTSTOWN PIKE
WEST CHESTER PA 19380-1103
610-431-9606

KENNEY, MD, NANCY T IM
2 JOSEPH PYLE DR
WEST GROVE PA 19390-1000
610-444-5676

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845 W CHESTER PIKE
WEST CHESTER PA 19382-4676
610-696-8100

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521 LOCUST LANE NORTH
WEST CHESTER PA 19380-2251

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P O BOX 533
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EXTON PA 19341-2533
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540 HOFFMAN DR
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610-431-5130

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6 PROSPECT AVE BOX 169
WEST GROVE PA 19390-1106
610-869-3593

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423 E CHESTNUT ST
COATESVILLE PA 19320-3234
610-383-1230

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57 N 4TH STREET
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610-932-8141

KOEPSELL, MD, DON G OPH
THE COMMONS AT
VALLEY FORGE
VALLEY FORGE PA 19460-2700
610-935-1211

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750 S MAIN ST STE 204
PHOENIXVILLE PA 19460-4460
610-983-3700

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960 HILLSDALE RD
WEST CHESTER PA 19382-1921

KOVALSKI, MD, RAYMOND PUD
750 S MAIN ST STE 100
PHOENIXVILLE PA 19460-4462
610-933-8484

KRAUS, MD, JOHN J PM
REHABILITATION ASSOC OF MAIN
MALVERN PA 19355-3300
610-251-5450

KRAUSER, MD, RONALD E RHU
PAOLI MEM MED BLDG
PAOLI PA 19301
610-647-2396

KRIPKE, MD, SCOTT A GS
PAOLI MEDICAL BLDG STE 327
PAOLI PA 19301
610-647-3077

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1011 W BALT PIKE STE 202
WEST GROVE PA 19390
610-869-1221

KRISHNA, MD, NARENDRA OPH
1102 N NEW ST
WEST CHESTER PA 19380-3838

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1775 W CHESTER PIKE
HAVERTOWN PA 19083-2934
610-431-2610

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564 CONESTOGA RD
BERWYN PA 19312-1363
215-823-5809

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WAYNE PA 19087-2006
610-431-5130

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1857 BLACK ROCK LN
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610-840-1884

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PAOLI PA 19301
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533 E LINCOLN HWY
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610-384-2484

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1289 LONE EAGLE ROAD
COATESVILLE PA 19320-9801
610-384-4303

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PHOENIXVILLE PA 19460-4456
610-933-2440

LEVIN, MD, GARY J OPH
1500 CARDINAL DR
COATESVILLE PA 19320-4506
610-384-9100

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1232 PRINCETON LN
WEST CHESTER PA 19380-5722

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595 S BIRMINGHAM RD
WEST CHESTER PA 19382-2163
610-696-6927

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631 HOLLOW RD
RADNOR PA 19087-2832
215-662-7310

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335 WHITEHORSE ROAD
PHOENIXVILLE PA 19460-2566

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606 E MARSHALL ST
WEST CHESTER PA 19380-4455
610-696-1230

LONG, MD, DAVID F N
414 PAOLI PIKE
MALVERN PA 19355-3311
610-251-5450

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PHOENIXVILLE PA 19460
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9 N FIVE POINTS RD
WEST CHESTER PA 19380-4739
610-696-8800

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1006 BALA FARMS
WEST CHESTER PA 19382-2345
610-431-0494

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WEST CHESTER PA 19380-4400
610-696-2570

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610-692-5217

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213 REECEVILLE RD STE 17
COATESVILLE PA 19320
610-383-9400

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479 THOMAS JONES WAY
EXTON PA 19341-2552
610-524-6470

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DOWNINGTOWN PA 19335-2722

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500 HADFIELD RD
DOWNINGTOWN PA 19335-1136
610-269-9966

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486 THOMAS JONES WAY
STE 110
EXTON PA 19341
610-524-6580

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750 S MAIN ST
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610-933-8484

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SOUTHERN CHESTER CTY
MED BLDG
WEST GROVE PA 19390
610-869-3620

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601 WESTTOWN RD
WEST CHESTER PA 19382-4542
610-344-6230

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795 E MARSHALL ST STE 304
WEST CHESTER PA 19380
610-436-5610

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NEUROLOGY
COATESVILLE PA 19320
610-384-7711

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1438 POTTSTOWN PIKE
WEST CHESTER PA 19380-1103
610-431-9606

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610-644-9456

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630 COPE RD
KENNETT SQUARE PA 19348-3613
610-444-5573

MC CHESNEY JR, MD,
CHARLES T HS
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THORNDALE PA 19320
610-384-2420

MC GEEHAN, MD, JOHN T R
50 BLUE STONE DR
CHADDS FORD PA 19317-9311

MC KINSTRY, MD, ROBERT B FP
546 SCHOOL HOUSE RD
KENNETT SQUARE PA 19348-1742

MC LAUGHLIN, MD, RAYMOND S FP
701 E BALTIMORE PIKE
KENNETT SQ PA 19348-2429
610-444-4060

MERSON, MD, ERICH R * GP
134 W CHESTNUT ST
WEST CHESTER PA 19380-2557
610-696-3606

METRY, MD, NAWAL G * PD
1558 MCDANIEL DR
WEST CHESTER PA 19380-7036
610-431-1616

MEYERS, MD, FREDERIC A * GE
213 REECEVILLE RD STE 38
COATESVILLE PA 19320-1538
610-384-6076

MICHAELSON, MD, THOMAS C IM
750 S MAIN ST
PHOENIXVILLE PA 19460-4462
610-933-8484

MINEO, MD, CYRUS L OPH
286 GRIFFIN ST
PHOENIXVILLE PA 19460-4446
610-933-1144

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3500 LINCOLN HWY
THORNDALE PA 19372-1017
610-384-2420

MONTE, MD, D MARIE GP
4405 FOX POINTE COURT
GLEN MILLS PA 19342-6145

MURDOCH, MD, WINSLOW W FP
GOSHEN FAM PRAC
WEST CHESTER PA 19380
610-692-4700

NAEGLE, MD, MATTHEW B IM
750 S MAIN ST STE 100
PHOENIXVILLE PA 19460-4462
610-933-8484

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24 RABBIT RUN
MALVERN PA 19355-3436

NICKLAS, MD, DONALD A PTH
2865 RINGNECK RD
AUDUBON PA 19403-1612
610-383-8088

O'HARA JR, MD, JOHN J CD
PAOLI MEMORIAL MEDICAL
PAOLI PA 19301
610-647-4260

O'MALLEY, MD, JOHN E CHP
DEVEREUX FOUNDATION
DEVON PA 19333-1533
610-964-3059

OST, MD, MARY A FP
402 MC FARLAND RD
KENNETT SQUARE PA 19346
610-444-5676

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1306 BUCHANAN AVE
OLEAN NY 14760-1604

PATUKAS, MD, PETER C FP
7 DOWNING RD
DOWNINGTOWN PA 19335-3324
610-383-3309

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414 PAOLI PIKE
MALVERN PA 19355
610-251-5450

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20 OLD PAOLI PIKE BOX 537
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602 E MARSHALL ST STE 11
WEST CHESTER PA 19380-4452
610-696-4626

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115 BIRMINGHAM RD
WEST CHESTER PA 19382-2101
610-696-3431

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PAOLI MEMORIAL MEDICAL BLDG
PAOLI PA 19301
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1008 N NEW ST
WEST CHESTER PA 19380-3836

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350 WALNUT AVE
WAYNE PA 19087-3624
610-688-2955

POTTER JR, MD, HOWARD P GE
208 IVY LN
HAVERFORD PA 19041-1721
POTTS, MD, ASA W IM
986 E PENN DR
WEST CHESTER PA 19380-4341
PRASAD, MD, AJIT K ORS
316 MAPLE DR
KENNETT SQUARE PA 19348-1810
PRESSMAN, MD, EDMUND N AN
1258 LAKEMONT RD
VILLANOVA PA 19085-2104
610-667-5390
PRIEM, MD, ROBERT W FP
13 BERKLEY RD AND DEVON BLVD
DEVON PA 19333-1310
610-687-0715
PUSHKAREWICZ, MD, MICHAEL J ORS
679 EWING RD
WEST GROVE PA 19390-9161
610-869-1266
RABIN, MD, SIDNEY C GYN
600 E MARSHALL ST
WEST CHESTER PA 19380-4454
610-692-3434
RAO, MD, BRINDA E PD
305 OXFORD PROFESSIONAL CENTR
OXFORD PA 19363
610-932-9116
REAL, MD, MARK B IM
405 HIGHLAND AVE
OAKS PA 19456
610-933-8484
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750 S MAIN ST
PHOENIXVILLE PA 19460-4459
REILLY, MD, ANN E IM
145 EATON DR
WAYNE PA 19087-3859
ROACHE, MD, MARTIN J GP
17 GRUBB RD
MALVERN PA 19355-3068
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WEST CHESTER PA 19380-4434
610-692-6330
ROBISON, MD, ELIZABETH A * GS
BRANDYWINE PROFESSIONAL BLDG
COATESVILLE PA 19320-1533
610-384-0580
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PHOENIXVILLE PA 19460-2787
610-971-5502
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PHOENIXVILLE PA 19460-4462
610-933-8484
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610-869-1084
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610-933-2440
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320 STRATHMORE ROAD
ROSEMONT PA 19010
215-748-9355
RONKIN, MD, SHEILA L MFM
300 CHERRY BEND
MERION PA 19066
ROONEY, MD, DAVID G * FP
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610-932-8141
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795 E MARSHALL ST
WEST CHESTER PA 19380-4400
610-431-7920
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750 S MAIN ST STE 300
PHOENIXVILLE PA 19460-4460
201-935-7772
ROSATO, MD, DONALD J * FP
176 E CONESTOGA RD
DEVON PA 19333-1211
610-688-0822
ROSS, MD, PATRICIA E PD
356 FORREST MANOR RD
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610-869-4060
ROSSI JR, MD, RALPH A DR
1204 UPTON CIR
WEST CHESTER PA 19380-5860
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750 S MAIN ST STE 307
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610-933-3182
ROWLEY, MD, RICHARD S OPH
720 S MAIN ST
PHOENIXVILLE PA 19460-3844
610-933-3498
RUBENSTONE, MD, JEANNE C EM
1490 ART SCHOOL RD
CHESTER SPRINGS PA 19425-1000
610-431-5150

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21 INDUSTRIAL BLVD STE 100
PAOLI PA 19301-1610
610-644-6900
RUSSELL JR, MD, BERTRAM R R
520 ROSE LN
HAVERFORD PA 19041-1623
SACKS, MD, EDMOND J PDC
6 TIVERTON CIR
RADNOR PA 19087-2615
610-640-9966
SALAM, MD, MAHI PD
106 SCHUBERT DR
DOWNINGTOWN PA 19335-3382
610-873-8882
SANDLER, MD, KENNETH R P
561 FAIRTHORNE AVE
PHILADELPHIA PA 19128-2412
215-487-4032
SANT RAM, MD, DEEPAK CD
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WEST GROVE PA 19390-9426
610-869-7151
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PAOLI MEMORIAL MEDICAL
PAOLI PA 19301
610-296-8844
SATRIALE, MD, ROBERT O PUD
319 N WOODMONT DR
DOWNINGTOWN PA 19335-3253
610-667-9080
SCHAAF, MD, HOMER D PTH
1232 N GATE RD
WEST CHESTER PA 19382
SCHEID, MD, VICKY L PD
1911 W BALTIMORE PK STE 102
WEST GROVE PA 19390
610-869-0680
SCHINDLER, MD, PETER D CHP
614 DENTON HOLLOW RD
WEST CHESTER PA 19382-7023
610-793-1979
SCHLESS, MD, ARTHUR P * P
560 PUGH RD
STRAFFORD PA 19087-1907
610-384-2277
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PHILADELPHIA PA 19107
215-955-1708
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1570 POORHOUSE RD
DOWNINGTOWN PA 19335
SCOTT, MD, J CLIFFORD P
WHITE HORSE VILLAGE G 148
NEWTOWN SQUARE PA 19073-2815
610-558-2656
SHIREY, MD, ELAINE D AN
142 CARTERS GRV
MALVERN PA 19355-2648
610-667-5413
SIEPSER, MD, STEVEN B * OPH
91 CHESTNUT RD
PAOLI PA 19301-1502
610-296-3333
SILVERBERG, MD, ALAN OBG
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PHOENIXVILLE PA 19460-4456
610-933-2440
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WEST CHESTER PA 19380
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810-431-9686
SMITH, MD, RUSSELL C AM
17 WOODLAND CIR
DOWNINGTOWN PA 19335-3346
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KENNETT SQUARE PA 19348-2608
610-444-2002
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710 E LANCASTER AVE
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610-524-3703
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750 S MAIN ST STE 203
PHOENIXVILLE PA 19460-4461
610-933-1133
SPENCER, MD, DONALD LYNN AN
PO BOX 401
KENNETT SQUARE PA 19348-0401
610-327-7186
SPYROPOULOS, DO, GEORGE N FP
102 DEVON DR
EXTON PA 19341-1743
302-477-3300
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WEST CHESTER PA 19380-4455
610-696-1230

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810-383-5610
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COATESVILLE PA 19320-3202
610-384-0250
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125 E VIRGINIA AVE
WEST CHESTER PA 19380-2344
610-431-2262
TADDONIO, MD, WILLIAM S FP
RR 1 2008 BLACKBIRD CIR
NORRISTOWN PA 19403
810-323-6835
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795 E MARSHALL ST
WEST CHESTER PA 19380
610-896-8900
TEMPLE, MD, ANTHONY R * EM
MCNEIL CONSUMER PRODUCT CO
FT WASHINGTON PA 19034
215-233-7763
THAKARAR, MD, PUSHPA US
902 MADISON DRIVE
MALVERN PA 19355-3101
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PAOLI PA 19301
610-644-9600
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COATESVILLE PA 19320-1531
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PAOLI PA 19301
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WEST CHESTER PA 19380-4454
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400 N WALNUT
WEST CHESTER PA 19380-2467
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WEST CHESTER PA 19380-4455
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140 NUTT RD
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WAHL, MD, JEFFREY M CD
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WEST CHESTER PA 19380
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GLEN MILLS PA 19342-8824
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PAOLI PA 19085-1914
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CLEARFIELD PA 16830-1021
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612 TREASURE LK
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9 W PAULINE DR
CLEARFIELD PA 16830-1011
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SCHAEFER, MD, KATHLEEN A N
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PHILIPSBURG PA 16866-1958
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BROWN, MD, JOHN L FP
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LOCK HAVEN PA 17745-1818
CONLY, MD, FRANK L FP
924 HURON AVE
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48 WOODLAND DR
LOCK HAVEN PA 17745-9655
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SOVETSKY, DO, CHARLES L R
30 OLD COVERED BRIDGE RD
NEWTOWN SQUARE PA 19073-1202
610-284-8319

SPENCER, MD, H NEWTON ORS
HAVERFORD ORTHO ASSOC
3RD FL
BROOMALL PA 19008
610-356-3700

SPINA JR, MD, JOSEPH OPH
767 WOODLEA RD
ROSEMONT PA 19010-1138

SRIVASTAVA, MD, BRIJ B ON
945 WATERS EDGE
MEDIA PA 19063-1184
610-626-5122

STAFFORD, MD, CALVIN R N
CROZER-CHESTER MED CENTER
CHESTER PA 19013-5313
610-874-1184

STAHLMAN, MD, ROY A EM
714 CLYDE CIR
BRYN MAWR PA 19010-1102
215-576-3850

STAHLNECKER, MD, C STEPHEN US
923 WINDING LN
MEDIA PA 19063-1655

STANKIEWICZ, MD, EDWARD R * IM
1579 CHICKESTER AVE
LINWOOD PA 19061
610-485-5800

STAPLES, MD, HERMAN D P
BEATTY AND PROVIDENCE RD
MEDIA PA 19063
610-565-2210

STARER, MD, LARRIMORE J OPH
6 MORTON AVE STE 101
RIDLEY PARK PA 19076-2210
610-521-2111

STAROS, MD, ERIC B PTH
410 HOLLY LN
WYNNEWOOD PA 19096-1617
610-645-2457

STEIN JR, MD, DONALD B * PTH
3000 ROBIN LN
HAVERTOWN PA 19083-1116
610-891-3299

STELLA, MD, HECTOR J * IM
CROZER CHESTER MED CENTER
UPLAND CHESTER PA 19013-3995
610-447-2000

STEVENS, DO, PHILIP J PM
1102 BERGAN RD
ORELAND PA 19075-2506
610-876-3500

STEVENSON, MD, KATHLEEN M IM
2505 BUCKEYE CIR
BLUE BELL PA 19422-3408
610-447-2000

STORM, MD, CHARLES T AN
912 RIDLEY CREEK DR
MEDIA PA 19063-4923

STROWHOUER, DO, WILLIAM J FP
GRANITE RUN OFFICE PLAZA
MEDIA PA 19063-5134
610-566-8885

SUGAR, MD, MIKLOS PD
235 S RIDLEY CREEK RD
MEDIA PA 19063-4215

SULLIVAN, MD, EDWARD M OBG
1076 W BALTIMORE PIKE
MEDIA PA 19063-5105
610-566-3500

SUNDT, MD, LINDA M AN
417 WYNTRE LEA DR
BRYN MAWR PA 19010-2038
215-928-3353

SURKIN, MD, MARC I OTO
400 BALLYTORE CIR
WYNNEWOOD PA 19096-2354
610-446-6900

SUTTON, MD, CHARLES S DR
912 SPRUCE APT 12
PHILADELPHIA PA 19107-6131

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WEST CHESTER PA 19380-0015

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15TH ST AND UPLAND AVE
UPLAND PA 19013
610-874-8491

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5 HILLTOP RD
WALLINGFORD PA 19086-6216
610-447-2517

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COMMUNITY HOSPITAL OF
CHESTER
CHESTER PA 19013
610-494-7711

TEANO, MD, DAN A NEP
5 THISTLE LANE
MEDIA PA 19063
610-485-1176

TERZIAN, MD, ALLEN E HEM
116 ALLGATES DR
HAVERFORD PA 19041-1056
215-612-5250
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1088 W BALTIMORE PIKE
MEDIA PA 19063-5136
610-565-7010
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CROZER-CHESTER MED CENTER
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610-874-2620
THORNTON III, MD, JAMES J GE
252 LANKENAU MEDICAL BLDG E
WYNNEWOOD PA 19096-3427
610-896-7360
THURMAN, MD, JOHN N IM
THE OUTPATIENT PAVILION 3408
MEDIA PA 19063-5139
610-565-6805
TIONGSON, MD, ELEANOR S * OBG
652 N HEILBRON DR
MEDIA PA 19063-4623
610-626-7488
TIONGSON JR, MD, JOSE G * IM
103 E RIDLEY AVE
RIDLEY PARK PA 19078-3025
610-532-4233
TOBIA, MD, ENIO W GP
747 LOUISE DR
SPRINGFIELD PA 19064-1525
215-203-7322
TOMLINSON, MD, JOHN W OPH
411 N MIDDLETOWN RD APT A132
LIMA PA 19063-4436
TORI, MD, JOSEPH N FP
15 N SWARTHMORE PIKE
RIDLEY PARK PA 19078
TORRENCE, MD, MICHAEL B * PD
23 W CHESTER PIKE STE 200
RIDLEY PARK PA 19078-1629
610-521-1297
TOTINO, MD, JOSEPH A OPH
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RIDDLE HEALTH CARE CTR II
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610-565-6445
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1078 W BALTIMORE PIKE STE G3
MEDIA PA 19063-5105
610-566-0523
TREVLYN, MD, DEAN W ORS
2004 SPROUL RD 1ST FL
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610-353-0800
TRIOLO, MD, JOSEPH DR
266-3C IVEN AVE
ST DAVIDS PA 19087-1436
610-237-4355
TROTZKY, MD, MARGRET S PD
820 FOSS AVE
DREXEL HILL PA 19026-2518
TULLAI, MD, JOHN AN
618 MEREDITH DR
MEDIA PA 19063-1714
TUMAIAN, MD, ARAM AN
9 KNIGHTS WAY
NEWTOWN SQUARE PA 19073-3027
610-284-8430
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MERCY CATHOLIC MED CTR-FITZ
DARBY PA 19023
610-237-4370
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1113 PUTNAM BLVD
WALLINGFORD PA 19086-6766
610-622-9590
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2010 W CHESTER PIKE
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774 E PROVIDENCE RD #C301
CLIFTON HEIGHTS PA 19018-4322
610-237-4000
VILLAREAL, MD, DANIEL F IM
LANSDOWNE AVE AND BAILEY RD
DARBY PA 19023
610-237-4000
VOGT, MD, MERLE A * OBG
207 BEAUMONT DR
WALLINGFORD PA 19086-6849
610-874-4206
WALICHUCK, MD, JOHN G GP
454 SPRING VALLEY RD
MEDIA PA 19063-5416

WALKER, MD, STEPHEN R U
565 S HEILBRON DR
MEDIA PA 19063-4549
610-521-4112
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2155 PARKTON LN
YORK PA 17404-1008
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5101 TOWNSHIP LINE ROAD
DREXEL HILL PA 19028
810-446-5550
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PHILADELPHIA PA 19146
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5001 SE BRANDYWINE WAY
STUART FL 34997-8782
WARE, MD, WILLIAM C IM
11 CAMBY CHASE
MEDIA PA 19063-4545
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WARNING II, MD, WILLIAM J * FP
5000 HILLTOP DR STE 1
BROOKHAVEN PA 19015-1229
810-874-4404
WEAN, MD, LAWRENCE P * IM
891 BALTIMORE PIKE
SPRINGFIELD PA 19064-3954
810-544-9690
WEBER, MD, GEORGE L OM
BENJAMIN WEST
BERWYN PA 19312-1324
610-626-6640
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DVIC
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261 INDIAN CREEK RD
WYNNEWOOD PA 19096-3405
610-642-1932
WEINBERG, MD, RICHARD A * D
930 SPROUL RD
SPRINGFIELD PA 19064-1217
610-544-7744
WEINER, DO, IRA H * FP
1218 MONTGOMERY AVE
NARBERTH PA 19072-1751
610-565-4900
WEISS, MD, RICHARD D R
186 LINDEN DR
ELKINS PARK PA 19117-1339
215-576-2050
WERTHEIMER, MD, MARC J IM
5 CLUSTERS CHELSEY DR
MEDIA PA 19063
610-565-8600
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1 MEDICAL CENTER BLVD STE 303
UPLAND PA 19013-3988
610-872-8501
WEYN, MD, ADRIAN S CD
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UPLAND PA 19013-5313
610-876-2400
WHELAN, MD, STEPHEN T D
401 BAIRD RD
MERION STATION PA 19066-1416
810-352-1353
WHITAKER, MD, H CRAIG OBG
PEARL HALL CROZER CHESTER
UPLAND PA 19013
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712 DARBY RD
HAVERTOWN PA 19083-4806
610-449-7220
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STATE COLLEGE PA 16804-0814
614-946-2697
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132 SEMINOLE AVE
NORWOOD PA 19074-1127
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119 PENNOCK PL
MEDIA PA 19063-3826
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111 DARTMOUTH AVE
SWARTHMORE PA 19081-1620
810-543-5909
WILKINSON, MD, ROSELISE H PD
8801 STENTON AVE
PHILADELPHIA PA 19118-2319
215-233-2050
WILLIAMS, MD, BURTON L R
6 ORCHARD LN
WALLINGFORD PA 19086-6707
WILLIAMS, MD, CHRISTOPHER A OPH
OPH SURG ASSOC INC STE 104
UPLAND PA 19013
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WITHAM, MD, REBECCA S * PS
RIDDLE MEMORIAL HLTH
CARE CTR
MEDIA PA 19063-5105
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WOHL-KRISTO, MD, CATHERINE V AN
5 PILGRIM LN
DREXEL HILL PA 19026-4607
WOLK, MD, DANIEL L FP
105 GRAYLING AVE
NARBERTH PA 19072-1901
610-359-1355
WOOD, MD, MADELINE S * FP
1428 PONDS EDGE RD
WEST CHESTER PA 19382-7714
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YAGNIK, MD, PRATAP M N
2 STEEPLECHASE DR
MEDIA PA 19063-1953
610-664-3888
YAGNIK, MD, REKHA P PD
2 STEEPLECHASE DR
MEDIA PA 19063-1953
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YARDNEY, MD, MARC J * IM
210 ORCHARD WAY
WAYNE PA 19087-4806
610-688-5266
YARON, MD, NOEMI S PTH
149 HIGHLAND CIR
BALA CYNWYD PA 19004-2909
810-595-6453
YEOMAN, MD, MARGARET P PS
1500 MONK RD
GLADWYNE PA 19035-1317
YODER, MD, MORRIS L IM
149 DECATUR RD
HAVERTOWN PA 19083-1105
YOW, MD, MICHAEL V CD
906 TWYCKENHAM RD
MEDIA PA 19063-1636
610-874-2521
YUM, MD, KEUK Y GS
334 LANKENAU MEDICAL BLDG
WYNNEWOOD PA 19096-3427
610-642-4004
YUZON, MD, RENATO D IM
171 ASHURST AVE
PRIMOS PA 19018-2044
215-427-7000
ZABEL, DO, CHRISTINE M FP
45 CEDARBROOK RD
ARDMORE PA 19003-1617
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891 BALTIMORE PIKE
SPRINGFIELD PA 19064-3954
610-544-9690
ZAKEOSIAN, MD, GARABET M * AN
3909 GRADYVILLE RD
NEWTOWN SQUARE PA 19073-3124
610-642-0330
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PROVIDENCE MEDICAL CENTER
MEDIA PA 19063
810-872-7660
ZEE, MD, MARY K EM
51 E KNOWLTON RD
MEDIA PA 19063-4926
ZEINER, MD, GEORGE B OM
214 MARGARET WAY
KENNETT SQUARE PA 19348-1308
610-591-3370
ZEMBA-PALKO, MD, VLASTA * PTH
100 LANCASTER AVE
WYNNEWOOD PA 19096
810-645-2606
ZHENG, MD, YUNLI IM
774 PROVIDENCE RD #C-408
ALDAN PA 19018-4331
610-237-4958
ZIEGENFUS, MD, WILLIAM D U
1088 W BALTIMORE PIKE # 2105
MEDIA PA 19063
810-565-8444
ZINTL, MD, WILLIAM J GS
3001 GARRETT ROAD
DREXEL HILL PA 19026
610-626-4665
ZORANSKI, DO, BERNARD S IM
201 WILMINGTON
GLEN MILLS PA 19342
810-358-9058
ZOUABI, MD, FIRAS IM
1600 GARRETTE RD #B204
UPPER DARBY PA 19083-4410
ZURBACH, MD, JAMES M ORS
PROF OFFICE BLDG
UPLAND PA 19013-3988
810-876-0347
ZWEBEN, MD, ALAN H * IM
309 COLONIAL DR
WALLINGFORD PA 19086-6003
810-876-1800

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CONWAY, MD, DAVID C * OBG
ANDREW KAUL MEMORIAL
HOSPITAL
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COPPOLO, MD, BERNARD L CD
121 ARCH ST
ST MARYS PA 15857-2151
814-834-2852
FLORES JR, MD, EMILIO G NM
ANDREW KAUL MEMORIAL
HOSPITAL
ST MARYS PA 15857-3498
814-781-1445
GICK, MD, STEPHEN A * ORS
781 JOHNSONBURG RD STE 220
ST MARYS PA 15857-3480
814-834-1688
JOLLY, MD, RAJ K OTO
20 N MICHAEL ST
ST MARYS PA 15857-1325
614-839-7720
JOSEPH, MD, KADANKAVIL C GS
129 N MICHAEL ST
ST MARYS PA 15857-1142
614-781-1188
KEARNEY, DO, STARR M IM
ELK COUNTY GEN HOSP
RIDGWAY PA 15853-1931
614-776-6111
LIN, MD, PU CHING R
816 N MAPLE AVE
RIDGWAY PA 15853-9753
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1210 TREASURE LAKE
DUBOIS PA 15801
614-371-5128
ORDIWAY, MD, M VERNON * P
220 CENTER ST
RIDGWAY PA 15853-1203
614-776-2126
PATANKAR, MD, JAYANT L FP
921 VINE ROAD EXT
SAINT MARYS PA 15857-2041
814-781-7500
PONTZER, MD, HERBERT GP
173 MAIN ST
RIDGWAY PA 15853-1034
814-773-5225
REGEC, MD, STEPHEN P OBG
DUBOIS REGIONAL MEDICAL CTR
DUBOIS PA 15801-0447
614-375-1068
SAND, MD, VIJAICHAND S U
254 EUCLID AVE
RIDGWAY PA 15853-1928
614-772-7400
SARGINGER, MD, LARRY J * FP
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ST MARYS PA 15857-1701
814-834-2850
SORIANO JR, MD, MANUEL G U
DOVE ST
ST MARYS PA 15857
SUBRAMANY, MD,
NARAYANASWAMY GS
129 N MICHAEL ST
ST MARYS PA 15857-1142
814-781-1188
THAKER, MD, UPENDRA N * AN
948 BILLE RD
ST MARYS PA 15857-3070
814-781-7500
THOMPSON, MD, WILLIAM W GP
107 CENTER ST
RIDGWAY PA 15853-1701
814-772-3841
UDARBE, MD, GUILLERMO G FP
102 CENTER ST
RIDGWAY PA 15853-1718
614-772-2363
VALIGORSKY, MD, PAUL J AN
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FORCE PA 15841-0043
WAGNER, MD, ROBERT E IM
RR 3 BOX 190A
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ALLANIGUE, MD, ROGELIO M IM
20 W HIGH ST
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ALLEN, MD, HUGH L IM
2323 EDINBORO RD APT 380A
ERIE PA 16509-3476
ALMASHAT, MD, ALA A * GS
MEDICAL ARTS BLDG
UNION CITY PA 16438
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41 W MAIN ST
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ALTMAN, MD, DANIEL T ORS
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814-870-6000
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ERIE PA 16504-1068
814-456-2047
ANDERSON, MD, GORDON P * CD
224 W 26TH ST
ERIE PA 16508-1673
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ANDERSON JR, MD, WILLIAM H GP
13633 RIDGE ROAD
WEST SPRINGFIELD PA 16443-0112
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ERIE PA 16508-2776
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ANTOON, DO, MICHAEL S EM
5902 COTTONWOOD DR
ERIE PA 16506-4706
814-868-3035
BAKER, MD, GRAEME C PS
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ERIE PA 16507-1430
814-453-4397
BALINT, MD, BART W AN
9434 FRANKLIN CENTER RD
CRANESVILLE PA 16410-9404
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ERIE PA 16507-1427
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110 HUNTERS CREEK RD
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FAIRVIEW PA 16415-1640

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CORRY PA 16407-1412
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814-459-1851

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ERIE PA 16508
814-454-3581

BU, MD, TAE-HYUNG OBG
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ERIE PA 16502-2722
814-452-4505

BURROWS, MD, CRAIG H FP
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ERIE PA 16502-1373
814-452-5100

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ERIE PA 16501-1746
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814-870-6000

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ERIE PA 16506-2504
814-870-7035

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1115 CHESTNUT HILL DR
ERIE PA 16509-2115

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407 OAKWOOD DR
WHITEHALL PA 18052-7217
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ELIAS, MD, ZEV * NS
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ALLENTOWN PA 18103
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FOGELSVILLE PA 18051-2240
ESLER JR, MD, JAMES W AN
451 W CHEW ST STE 406
ALLENTOWN PA 18102-3424
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2335 RIVERBEND RD
ALLENTOWN PA 18103-9660
FARR, MD, JAMES OBG
180 N 12TH ST
LEHIGHTON PA 18235-1115
610-377-3652
FARRELL, MD, PETER E OTO
WEST ROCK RD "ARDSHEAL"
ALLENTOWN PA 18103
610-770-9393
FELDMAN, DO, NEIL H AI
1398 DOE TRAIL RD
ALLENTOWN PA 18104-2053
610-437-0711
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501 N 17TH ST
ALLENTOWN PA 18104-5044
610-435-8562
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1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-770-0616
FIELD MUNVES, MD, ELLEN M RHU
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BETHLEHEM PA 18017-7474
610-691-6222
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40 S CEDAR CREST BLVD
ALLENTOWN PA 18104-5912
610-433-7589
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ALLENTOWN PA 18103
610-433-4852
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1162 BELLAIR DR
ALLENTOWN PA 18103-5404
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528 N 25TH ST
ALLENTOWN PA 18104-4921
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451 W CHEW ST STE 306
ALLENTOWN PA 18102-3423
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ALLENTOWN PA 18104-2253
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3761 DEVONSHIRE RD
ALLENTOWN PA 18103-9628
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1020 S CEDAR CREST BLVD
ALLENTOWN PA 18103
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334 N 26TH ST
ALLENTOWN PA 18104-4924
GEE, MD, WILLIAM * VS
1524 W LINDEN ST
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3131 COLLEGE HEIGHTS BLVD
ALLENTOWN PA 18049-1258
610-437-1931
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3710 BROADWAY
ALLENTOWN PA 18104-5218
610-395-0307
GEVIRTZ, MD, JEFFREY L U
1251 S CEDAR CREST BLVD #305D
ALLENTOWN PA 18103-6205
610-432-7780
GIANGIULIO, MD, DENNIS J * ON
450 PERSHING BLVD
WHITEHALL PA 18052-6452
610-435-6966
GINSBERG, MD, GENE H IM
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-434-2044
GITTLEMAN, MD, MARK A GS
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ALLENTOWN PA 18103-6208
610-439-4055
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322 S 17TH ST
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ALLENTOWN PA 18104-5524
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ALLENTOWN PA 18104-4664
610-432-5202
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ALLENTOWN PA 18104-5053
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GOLDNER, MD, DAVID B CD
3340 HAMILTON BLVD
ALLENTOWN PA 18103-4537
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GOLDSMITH, MD, CHARLES P OPH
930 S HILLVIEW RD
ALLENTOWN PA 18103-6154
GOOD, MD, HARRY S GS
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ALLENTOWN PA 18104-5627
GOODREAU, MD, JAMES J VS
PERIPHERAL VASCULAR SURG PC
ALLENTOWN PA 18103-6207
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401 N 17TH ST STE 304
ALLENTOWN PA 18104-5051
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GORDON, MD, CHARLES A IM
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
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ALLENTOWN PA 18103-6212
610-770-1350
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1575 POND RD STE 203
ALLENTOWN PA 18104-2254
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1259 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6206
610-439-0400
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401 N 17TH ST STE 306
ALLENTOWN PA 18104-5051
610-433-8853
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SACRED HEART HOSPITAL
ALLENTOWN PA 18102
610-439-1666
GULOTTA, MD, PAUL CD
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-437-5505
GUZZO, MD, JOSEPH C NEP
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-432-4529
HALL, MD, DONALD T US
1330 N 14TH ST APT V24
WHITEHALL PA 18052-7595
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1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
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2895 HAMILTON BLVD STE 103
ALLENTOWN PA 18104-6172
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4573 N HEDGEROW DR
ALLENTOWN PA 18103-6026
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227 N 26TH ST
ALLENTOWN PA 18104-5339
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ALLENTOWN PA 18104-5348
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50 S 16TH ST
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ALLENTOWN PA 18104-2116

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POCONO LAKE PRES PA 18348
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ALLENTOWN PA 18104-5218
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ALLENTOWN PA 18104-5604
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1605 LEHIGH PKY N
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610-791-2010

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17TH & CHEW STS
ALLENTOWN PA 18105-7017
610-402-2890

KLEAVELAND, MD, JOSEPH P CD
3340 HAMILTON BLVD
ALLENTOWN PA 18103-4537
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1275 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6207
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1679 LEHIGH PKY N
ALLENTOWN PA 18103-2913

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431 CHESTNUT ST
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2611 PARKWAY BLVD
ALLENTOWN PA 18104-5362

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2895 HAMILTON BLVD
ALLENTOWN PA 18104
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KNECHT, MD, CHARLES L R
3131 COLLEGE HEIGHTS BLVD
ALLENTOWN PA 18104-4858
610-435-2001

KNOUSE, MD, MARK C ID
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-7991
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KOCH, MD, THOMAS J OTO
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ALLENTOWN PA 18102-3424
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50 S 18TH ST
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4435 FARM DR
ALLENTOWN PA 18104-1937
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40 S CEDAR CREST BLVD
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1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
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LAWRENCE, MD, STEVEN J * ORS
1243 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6268
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ALLENTOWN PA 18104-2867
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825 N CEDAR CREST BLVD
ALLENTOWN PA 18104-3437
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1210 S CEDAR CREST BLVD
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1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-433-3143

MORROW-CONNELLY, DO, RENEE D PD
10 CLIFFTOP RD
NORTHAMPTON PA 18067-9552
610-435-6352

MORSE, MD, RICHARD J PD
401 N 17TH ST
ALLENTOWN PA 18104

MULLIN JR, MD, EDWARD M * U
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-437-9988

MUNCHAK JR, MD, JOHN GP
440 RIDGE AVE
ALLENTOWN PA 18102-5212
810-434-8154

MURPHY, MD, BRIAN P * U
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-437-9988

MURPHY JR, MD, ROBERT X * HS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-432-1953

NADER, MD, JOSEPH N CD
401 N 17TH ST STE 308
ALLENTOWN PA 18104-5051
610-434-5592

NAVARRO, MD, NORMAN F OBG
425 BRIGHTON ST APT 307
BETHLEHEM PA 18015-1246

NEDWICH, MD, ALEXANDER PTH
1461 RED MAPLE LN
ALLENTOWN PA 18104-2009

NGUYEN, MD, MINHLY T ID
1802 PICCADILLY CIR
ALLENTOWN PA 18103-6466

NICHOLAS, MD, GARY G * GS
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-432-1214

O'HARA, DO, MARY BETH A IM
818 EAGLE DR
EMMAUS PA 18049
215-402-8999

OGOKE, MD, BENTLEY A * IM
709 BROOKFILED CIR
MACUNGIE PA 18062-1156
610-402-8216

OKUNSKI, MD, WALTER J PS
LVHC MED OFFICE BLDG STE 204
ALLENTOWN PA 18103-6212
610-432-1953

OLIVER, MD, GLEN L * OPH
400 N 17TH ST STE 200
ALLENTOWN PA 18104-5052
610-820-6320

ORDWAY JR, MD, EUGENE E * CD
451 CHEW ST STE 302
ALLENTOWN PA 18102-3423
610-821-2610

ORR, MD, PAUL L P
2844 PENNSYLVANIA ST
ALLENTOWN PA 18104
610-435-4555

OTERO, MD, JORGE A * PD
1728 W JONATHAN ST
ALLENTOWN PA 18104-3120
610-776-4141

PANEBIANCO, MD, ANTONIO C CD
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-770-1350

PAPOLA, MD, JOHN S OTO
729 N 25TH ST
ALLENTOWN PA 18104-3931
610-437-5222

PASCAL, MD, JOSEPH U
1251 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6205
610-432-7760

PATRIARCO, DO, MICHAEL S OBG
3468 STURBRIDGE PL
ALLENTOWN PA 18104-1753
610-437-1931

PETERS, MD, CHARLES D IM
401 N 17TH ST STE 201
ALLENTOWN PA 18104-5050
610-432-6862

PETRASEK, MD, E BRIAN GS
2926 FERNOR ST APT Y-2
ALLENTOWN PA 18103-7061
610-402-8000

PETZ, MD, COLIN J IM
1106 EAGLE DR
EMMAUS PA 18049-1949

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1831 W LINDEN ST
ALLENTOWN PA 18104-5663
810-770-9111

PHILLIPS, MD, THEODORE G CDS
1230 S CEDAR CREST BLVD # 202
ALLENTOWN PA 18103-6212
610-770-1350

POST, MD, ROBERT M ON
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610-433-6691

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451 W CHEW ST STE 306
ALLENTOWN PA 18102-3423
610-821-2850

PRAGER, MD, DAVID ON
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610-433-6691

PROOTHI, MD, SUBHASH C ON
701 OSTRUM ST STE 302
BETHLEHEM PA 18015-1152
610-867-3115

PRYBLICK, DO, GARY M * FP
5422 HOLIDAY DR
ALLENTOWN PA 18104-9439
610-770-8300

PRYBLICK, DO, JUDITH R * FP
1901 HAMILTON ST STE 2
ALLENTOWN PA 18104-9439
810-437-7181

PURCELL, DO, STEPHEN M * D
2200 HAMILTON ST STE 108
ALLENTOWN PA 18104
610-770-1922

PUSCHAK, MD, RUSSELL B PD
401 N 17TH ST STE 210
ALLENTOWN PA 18104-5050
610-821-4920

QUEVEDO, MD, JONATHAN P PM
5TH AND ST JOHN STS
ALLENTOWN PA 18103
610-776-3276

RAMOS-CARO, MD, JOSE L * PD
1728 JONATHAN ST
ALLENTOWN PA 18104
610-776-4141

IAPHAEL, MD, PAUL S PM
1314 ANTLER CT
ALLENTOWN PA 18104
610-776-4520

IAPPAPORT, MD, MELVIN M FP
2327 FOX MEADOW DR
ALLENTOWN PA 18104-6672
610-262-9003

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911 COLD SPRING RD APT 4
ALLENTOWN PA 18103-7412
610-402-8999

EINBOLD, MD, PAUL M IM
1065 BERNICE DR
COPLAY PA 18037-1742

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525 N OTT ST
ALLENTOWN PA 18104-4233

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ALLENTOWN PA 18103-5354
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2200 W HAMILTON ST
ALLENTOWN PA 18104-6329

ESPET, MD, PATRICK B * ORS
1243 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6268
610-433-6045

EX, MD, JAMES C CRS
1760 MANCHESTER RD
ALLENTOWN PA 18104-2240

HODES, MD, MICHAEL TRS
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-402-8445

HODES III, MD, LUTHER V ID
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-7991
610-402-8430

ICE, MD, NATALIE M FP
1772 2ND ST
WHITEHALL PA 18052-5917

IENZO, MD, ROBERT J * DR
1200 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6202
610-402-8383

IETHER, MD, ROBERT D CRS
1275 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6207
610-433-7571

IOENBERGER, MD, BRUCE M OBG
1251 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6205
610-820-5800

IGERS, DO, JEFFREY S AN
1433 SPRUCE ST
WHITEHALL PA 18052-1107
609-937-8751

ISEN, MD, LESTER CRS
1275 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6207
610-433-7571

ISEN, MD, RANDY A NEP
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-432-4529

ISENAU, DO, ALEXANDER M EM
VHC DEPT/EMER MED
ALLENTOWN PA 18103
610-402-8130

ISENBERG, MD, HOWARD D DR
1741 DEVONSHIRE RD
ALLENTOWN PA 18103-9626
610-402-8088

SS, MD, ABRAHAM AN
501 W CHEW ST STE 406
ALLENTOWN PA 18102-3424
610-821-2820

SS, MD, DANIEL I OPH
1504 W ALLEN ST
ALLENTOWN PA 18104-5053
610-435-0956

SS, MD, DAVID S IM
15 RUTH RD
GUILFORD PA 18969-2328

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1227 WINCHESTER RD
ALLENTOWN PA 18104-1929
610-433-6442

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1555 GULF TO BAY BLVD APT 38-
CLEARWATER FL 34619-4016

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ARVIN K OTO
700 N 6TH ST
ALLENTOWN PA 18102-4013

VITO, MD, PETER F GS
702 N 19TH ST
ALLENTOWN PA 18104-4039
610-437-6119

FT, MD, BARRY A * ORS
1201 N CEDAR CREST BLVD
ALLENTOWN PA 18104-2307
610-821-4848

OR, MD, FARROKH S CDS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-770-1350

MIES, MD, JOHN H ID
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-7991
610-402-8430

SARACHEK, MD, NORMAN S CD
1351 HIGHLAND CT
ALLENTOWN PA 18103-6025
610-437-5505

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1615 SHERWOOD RD
ALLENTOWN PA 18103-2946

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401 N 17TH ST STE 311
ALLENTOWN PA 18104
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1401 N CEDAR CREST BLVD
ALLENTOWN PA 18104-2307
610-821-4848

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5239 HAMILTON BLVD
ALLENTOWN PA 18106-9714
610-398-2800

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GLENMOORE PA 19343

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1317 W HAMILTON ST
ALLENTOWN PA 18102-4314
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3340 HAMILTON BLVD
ALLENTOWN PA 18103-4537
610-433-6442

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2475 RIVER ROCK DR
MACUNGIE PA 18062-9098
610-435-8352

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1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-439-8856

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2895 HAMILTON BLVD STE 103
ALLENTOWN PA 18104-6172
610-776-7951

SECKINGER, MD, RAYMOND P P
451 W CHEW ST STE 301
ALLENTOWN PA 18102-3423
610-821-2808

SEWARDS, MD, PATRICK M * ORS
514 N 24TH ST
ALLENTOWN PA 18104-4917
610-433-4490

SHAMPAIN, MD, MARK P AI
3131 COLLEGE HEIGHTS BLVD
ALLENTOWN PA 18104-4858
610-820-7611

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401 N 17TH ST STE 307
ALLENTOWN PA 18104-5051
610-434-2162

SHAPIRO, MD, ERIC D IM
143 SOCIETY PARK CT
EMMAUS PA 18049-4230

SHEETS, MD, JAMES A CRS
1275 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6207
610-433-7571

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SACRED HEART HOSPITAL
ALLENTOWN PA 18102
610-776-4662

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ALLENTOWN PA 18104-5052
610-432-5100

SHOEMAKER, MD, ELLIOT I R
4215 E TEXAS RD
ALLENTOWN PA 18103-9757
610-402-8088

SHOEMAKER, MD, PATRICIA L PD
401 N 17TH ST
ALLENTOWN PA 18104-5049
610-435-3562

SHOENBERGER, MD, DOUGLAS C * FP
29 S OTT ST
ALLENTOWN PA 18104-6119
610-282-1170

SHOLEHVAR, MD, JAVAD OTO
ALLEN EAR NOSE AND THROAT
ALLENTOWN PA 18104-2254
610-366-7788

SHOLEVAR, MD, FARHAD * P
1840 SHERWOOD RD
ALLENTOWN PA 18103-2943
610-435-8986

SIEGFRIED, MD, MYRTLE M GP
2745 PARKWAY BLVD
ALLENTOWN PA 18104-5376

SILVERBERG, MD, BRUCE J CD
3340 HAMILTON BLVD
ALLENTOWN PA 18103-4537
610-433-6442

SILVERBERG, MD, DANIEL M * U
1255 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6256
610-432-1423

SILVERMAN, MD, HOWARD A FP
3131 COLLEGE HEIGHTS BLVD
ALLENTOWN PA 18104-4858
610-435-0611

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2147 W UNION ST
ALLENTOWN PA 18104-6445

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5137 KERNSVILLE RD
OREFIELD PA 18069-2323
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SINGER, MD, RAYMOND L * TS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103
610-770-1350

SINGER, MD, WILLIAM H AN
451 W CHEW ST STE 406
ALLENTOWN PA 18102-3424
610-821-2820

SIPES, MD, EARL K GS
2602 LINDBERG AVE
ALLENTOWN PA 18103-9607
610-435-7443

SIROTTA, MD, PAUL S NM
1200 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6202
610-402-8383

SKWEIR, MD, LEON A P
2060 MINESITE RD
ALLENTOWN PA 18103-9632
610-821-1344

SLOMPAK, MD, CAROL A IM
101 ST PETERS RD
MACUNGIE PA 18062-9241
610-682-1433

SMITH, MD, JERE P PD
401 N 17TH ST STE 307
ALLENTOWN PA 18104
610-434-2162

SMITH JR, MD, GEORGE S OBG
451 CHEW ST STE 309
ALLENTOWN PA 18102-3423
610-821-2830

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156 AMY AVE
ELIZABETHTOWN KY 42701-8409

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627 W WYOMING ST
ALLENTOWN PA 18103-3961
610-435-8643

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4862 SYDNEY CLOSE
MACUNGIE PA 18062-9515

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1317 W HAMILTON ST
ALLENTOWN PA 18102-4314
610-437-5433

SOUDER, MD, C LAWRENCE P
207 W SUMMIT ST APT A212
SOUDERTON PA 18964-2054

SPLAIN, DO, DENNIS J R
1529 WETHERSFIELD DR S
ALLENTOWN PA 18104-1947
610-776-4662

STAMATAKOS, MD, MICHAEL J R
917 N 29TH ST
ALLENTOWN PA 18104-3844
610-776-4662

STASIK JR, MD, JOHN J CRS
1275 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6207
610-433-7571

STEIN, MD, ARTHUR V PS
2597 SCHOENERSVILLE RD
BETHLEHEM PA 18017-7331
610-882-9112

STELZER, MD, FREDERIC A GE
451 W CHEW ST STE 401
ALLENTOWN PA 18102-3424
610-821-2828

STEPHENS JR, MD, HARRY W NS
2340 RIVERBEND RD
ALLENTOWN PA 18103-9226

STEWARD, MD, JOANNE A IM
2278 APPLE DR
FOGELSVILLE PA 18051-9797
610-395-3400

STIERSTORFER, MD, MAX J GP
1123 N VAN BUREN ST
ALLENTOWN PA 18103-1747
610-435-2267

STODDARD, MD, NEIL W IM
621 DELAWARE AVE 3RD FL
BETHLEHEM PA 18015-1192

STOLZ, DO, RALPH E GP
555 HARRISON ST
EMMAUS PA 18049-2339
610-967-3115

STRAUSS, MD, ROBERT D HNS
1251 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6205
610-439-1501

SUSSMAN, MD, DAVID ORS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-820-9629

SUSSMAN, MD, SYLVIA AN
3045 W WHITEHALL ST
ALLENTOWN PA 18104-3866
610-437-9433

SWAYSER, DO, WILLIAM R * IM
32 BEAVER RUN DR
QUAKERTOWN PA 18951-2753
215-282-4648

TAN, MD, ANTONIUS H DR
2855 GOLF CIR
EMMAUS PA 18049-1733
610-439-0868

TATE, MD, FREDERICK J FP
3305 MUNICIPAL DR
WHITEHALL PA 18052-2907

TAUS, DO, JOHN K GE
451 W CHEW ST STE 401
ALLENTOWN PA 18102-3424
610-821-2828

TERMINI, MD, JOSEPH T GP
942 S CEDAR CREST BLVD
ALLENTOWN PA 18103-3609
610-435-2827

THEIN, MD, WIN FP
25 JORDAN DR APT 11
WHITEHALL PA 18052-7850
610-776-4888

THOMAS, MD, ALEX T P
3533 SKYLINE DR
BETHLEHEM PA 18017-2082
610-821-6211

THOMPSON, MD, ROBERT J * D
6184 PUTTER DR
WESCOSVILLE PA 18106-9608
610-437-5433

TINIANOW, MD, LLOYD N P
919 N 24TH ST
ALLENTOWN PA 18104-3605
610-954-4434

TIU, MD, JOHN L IM
LEHIGH VALLEY HOSP MEDICINE
ALLENTOWN PA 18103
610-402-8200

TOFF, DO, KENNETH J PD
THE CHILDRENS HEALTHCARE CTR
ALLENTOWN PA 18104-2253
610-395-4444

TOMEZSKO, MD, JANET E OBG
636 S FRONT ST
ALLENTOWN PA 18103-3390
610-778-2300

TRACHTENBERG, MD,
WILLIAM M OPH
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ALLENTOWN PA 18104-3189
610-437-4988

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WHITEHALL PA 18052-7593
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2716 RUSSELL ST
ALLENTOWN PA 18104-2437
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2923 W GORDON ST
ALLENTOWN PA 18104-4615

TRIMPI, MD, HOWARD D CRS
153 SOCIETY PARK CT
EMMAUS PA 18049-4230

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1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
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1251 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6205
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3748 W HIGHLAND ST
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VERNICK, MD, CLIFFORD G ORS
1243 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6268
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VIECHNICKI, MD, M BRUCE * OBG
3131 COLLEGE HEIGHTS BLVD
ALLENTOWN PA 18104-4858
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2745 PARKWAY BLVD
ALLENTOWN PA 18104-5376

VIGNERI, DO, PHILLIP M * RO
DEPT OF RAD ONCOLOGY
ALLENTOWN PA 18102
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VINCENT, MD, JOSEPH E PUD
1210 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6208
610-439-8856

WALL, MD, JAMES R D
2895 HAMILTON BLVD
ALLENTOWN PA 18104-6172
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2730 MOSSER ST
ALLENTOWN PA 18014-2821

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1453 W LINDEN ST
ALLENTOWN PA 18102-4235
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WEISS, DO, ROBERT J NEP
50 S 16TH ST
EASTON PA 18042-3912
610-258-3608

WELKIE, MD, JOHN F GS
PERIPHERAL VASCULAR
SURGEONS
ALLENTOWN PA 18103
610-439-0372

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1691 GEORGIA DR
WHITEHALL PA 18052-4150

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3229 N FRONT ST
WHITEHALL PA 18052-3140
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7031 CARLS HILL RD
ZIONSVILLE PA 18092-2208

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97 FREDRICKSVILLE RD
MERTZTOWN PA 19539-9743
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1988 MYLINDA LN
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1251 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6205
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246 N 6TH ST
LEHIGHTON PA 18235-1310
610-377-2224

YEISLEY, MD, GEARY L TS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-770-1350

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1726 W JONATHAN ST STE 101
ALLENTOWN PA 18104-3120
610-432-2706

YIP, MD, LUKE C CDS
1230 S CEDAR CREST BLVD
ALLENTOWN PA 18103-6212
610-770-1350

ZAGER, MD, MICHAEL L IM
317 BROOKFIELD CIR
MACUNGIE PA 18062-1172

ZEMANEK, MD, KENNETH J * P
1243 S CEDAR CREST BLVD 2800
ALLENTOWN PA 18103-6296
610-402-9800

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ALLENTOWN PA 18102-3424
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1931 ENGLEWOOD TER
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20 N LAUREL ST STE GE
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717-824-3521

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717-826-7757

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215-947-6690

COHAN, MD, HAL D FP
2610 WISTER CT
LANSDALE PA 19446-6000
215-393-9950

COHEN, MD, DAVID E AN
227 ALMUR LN
WYNNEWOOD PA 19096-1712
215-590-1881

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411 GILPIN RD
NARBERTH PA 19072-1614
610-667-6172

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2000 VLY FORGE CIR APT 1024
KING OF PRUSSIA PA 19406-1119

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933 N CHARLOTTE ST
POTTSTOWN PA 19464
610-327-1220

COLCHER, MD, IRVING S PD
2795 EGYPT RD
AUDUBON PA 19403-2254
610-666-7076

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1033 E GERMANTOWN PIKE
NORRISTOWN PA 19403-2311
610-539-8500

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BRYN MAWR MED BLDG N STE 306
BRYN MAWR PA 19010
610-527-1185

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425 CARLTON AVE
WYNCOTE PA 19095-2015

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2300 COMPUTER AVE BLDG E-25
WILLOW GROVE PA 19090
215-659-8080

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1280 ARGYLE ROAD
BERWYN PA 19312-2052

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229 CONSHOHOCKEN STATE RD
GLADWYNE PA 19035-1331

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215-576-2000

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2300 COMPUTER AVENUE
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215-884-5600

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35 E WYNNEWOOD RD
WYNNEWOOD PA 19096-1917
610-215-3884

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1125 DUNDEE DR
DRESHER PA 19025-1615
215-576-1776

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S BROAD ST AND ALLENTOWN RD
LANSDALE PA 19446-5374
215-855-9501

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1412 MELROSE AVE
MELROSE PARK PA 19126-1114
215-871-1000

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ABINGTON PA 19001
215-572-5270

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5TH AND FORD STS
BRIDGEPORT PA 19405
610-279-4977

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777 GERMANTOWN PIKE
LAFAYETTE HILL PA 19444-1620
610-275-9816

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71 QUAKER DR
NEWTOWN PA 18940-1184
215-947-9272

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PO BOX 1276
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WYNNEWOOD PA 19096-3409
610-642-3255

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610-645-2802

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111 N 49TH ST
PHILADELPHIA PA 19139-2716
215-471-2527

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1411 POWELL ST
NORRISTOWN PA 19401-3356
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1513 WILLOW ST
NORRISTOWN PA 19401-3337

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298 S ROBERTS RD
ROSEMONT PA 19010-1351
610-526-3581

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14 LOUELLA CT #1STFL
WAYNE PA 19087-3526
610-688-8240

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842 MOUNT PLEASANT RD
BRYN MAWR PA 19010-1824
610-526-3453

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DRESHER PA 19025-1435
215-233-4440

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POTTSTOWN PA 19464
610-323-5550

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BLUE BELL PA 19422-1565

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BLUE BELL PA 19422-3313
717-884-5566

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905 VALLEY GLEN RD
ELKINS PARK PA 19117-1749

DAVIS, MD, EDWARD W GP
137 ORCHARD CT
BLUE BELL PA 19422-2834

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1124 SHAW DR
FT WASHINGTON PA 19034-1727
215-443-8625

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BRYN MAWR HOSPITAL
BRYN MAWR PA 19010-3143
610-526-3553

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700 JOSEPH DR
WAYNE PA 19087-1021
610-783-5025

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215-745-4050

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215-288-5000

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610-667-4289

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BOCA RATON FL 33432-7835

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215-256-8040

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662 DODDS LANE
GLADWYNE PA 19035-1424
610-265-0184

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610-275-7220

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PHILADELPHIA PA 19116-2627

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600 GAWAIN RD
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100 CHURCH RD
ARDMORE PA 19003-2316
610-649-6481

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1519 MEDICAL DR
POTTSTOWN PA 19464-3224
610-326-8005

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602 S BETHLEHEM PIKE
AMBLER PA 19002
215-643-7771

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491 ALLENDALE STE 307
KING OF PRUSSIA PA 19406
610-265-2240

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1245 HIGHLAND AVE
ABINGTON PA 19001-3714
215-886-7000

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310 CONESTOGA RD
WAYNE PA 19087-4701
610-525-8450

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NORRISTOWN PA 19401-3350
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BLDG NORTH
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610-527-1604

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2132 KEITH RD
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191 PRESIDENTIAL BLVD APT 105
BALA CYNWYD PA 19004-1208
610-667-3341

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223 POLO DR
NORTH WALES PA 19454-4245
215-221-4200

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1603 E HIGH ST
POTTSTOWN PA 19464-5061
610-327-2400

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119 MILL CREEK RD APT D2-N
ARDMORE PA 19003-1535

DRATCH, MD, ADAM D IM
435 OLDE BRIDGE RD APT C2
ANDALUSIA PA 19020-7763

DRISCOLL, MD, GENEVRA Z P
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NARBERTH PA 19072-1104

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S BROAD ST AND ALLENTOWN RD
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MELROSE PARK PA 19126-1301

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JENKINTOWN PA 19046-3913

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491 ALLENDALE RD
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LANSDALE PA 19446-2408
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ABINGTON PA 19001-3714
215-886-1482

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3 SHALIMAR LN
MAPLE GLEN PA 19002-3054

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GWYNEDD VALLEY PA 19437-0285
610-272-4550

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240 MERION RD
MERION STATION PA 19066-1751
610-664-3211

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1529 DEKALB ST
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610-277-3690

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332 ARDMORE AVE
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215-662-3782

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669 PINETREE RD
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610-527-1782

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1411 POWELL ST
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610-279-8300

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840 COUNTY LINE RD
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610-527-1510

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BRYN MAWR HOSPITAL
BRYN MAWR PA 19010-3143
610-526-3453

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317 OAKTREE COURT
FREDERICK PA 19435-0548
610-326-6041

EVANS, MD, JOHN B PD
RED ROWEN LN
PLYMOUTH MTNG PA 19462
215-825-3500

EWING, MD, CHARLES H FP
RYDAL PARK
RYDAL PA 19046
215-885-6800

FAIRFIELD, MD, JAMES C D
LANSDALE MEDICAL GROUP
LANSDALE PA 19446-0508
215-855-9501

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4596-A VALLEY PARKWAY
SMYRNA GA 30082
FALK, MD, ARTHUR E OBG
8880 S OCEAN DRIVE #301
JENSEN BEACH FL 34957
FALKER, MD, JOHN M * DR
1648 HUNTINGDON PIKE
MEADOWBROOK PA 19046-8001
215-947-3000
FANG, MD, JOHN Y N
834 CHESTNUT STREET APT 1523
PHILADELPHIA PA 19107-5147
FARB, MD, STANLEY N OTO
306 W LOGAN ST
NORRISTOWN PA 19401-2973
610-275-6153
FAROOQUE, MD, MUSTAFA P
2231 BROOKVIEW PL
ELKINS PARK PA 19117-2804
215-456-7690
FAYNBERG, MD, NORA GP
5827 RISING SUN AVE
PHILADELPHIA PA 19120-1143
215-745-5083
FEE, MD, EUGENE A P
821 MANCILL MILL RD
KING OF PRUSSIA PA 19406-1101
610-327-2007
FEIN, DO, HOWARD K GP
922 FAYETTE ST
CONSHOHOCKEN PA 19428-1565
610-825-3464
FELDMAN, MD, ELLEN K P
612 BUSTLETON PIKE
RICHBORO PA 18954-1357
215-938-4908
FENN, MD, PATRICIA A RHU
933 HAVERFORD RD
BRYN MAWR PA 19010-3819
610-525-4483
FENSTEMACHER, MD, PAMELA A FP
617 OLD YORK ROAD
JENKINTOWN PA 19046
215-576-2725
FILIP, MD, JOHN R * IM
1073 MONTGOMERY AVE
PENN VALLEY PA 19072-1605
215-482-0900
FILOSA, MD, ROBERT J OBG
LANSDALE MEDICAL GROUP SOUTH
LANSDALE PA 19446-2408
215-855-9501
FINE, MD, ROBERT EM
1619 KINGS MILL ROAD
GWYNEDD VALLEY PA 19437
610-645-2288
FINGERUT, MD, JERALD C GE
1330 POWELL ST STE 310
NORRISTOWN PA 19401
610-277-2635
FINGO, MD, ALBERT J FP
300 BEACH RD APT 208
TEQUESTA FL 33458
407-746-5333
FINK, MD, JACK W GYN
2303 N BROAD ST
COLMAR PA 18915-9786
215-997-8969
FINKELSTEIN, DO, LEONARD H * U
GSB BLDG STE 714
BALA CYNWYD PA 19004
610-667-3020
FISHER, MD, NORMAN J FP
197 E MILL RD
HATBORO PA 19040-4009
FISHER, MD, ROBERT M FP
447 GREAT SPRINGS RD
BRYN MAWR PA 19010-1715
610-525-4547
FITZGERALD, DO, JOHN J OBG
760 JOHNS LN
AMBLER PA 19002-2616
610-279-6621
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835 BEHLEWOOD AVE
COLLINGSWOOD NJ 08108
215-955-7546
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1200 YORK RD
ABINGTON PA 19001-4706
215-576-2336
FORMAN, MD, STANLEY O A
222 UPLAND RD
MERION STATION PA 19066-1622
610-275-9340
FOSTER, MD, SYLVIA L * P
1021 W UPSAL ST
PHILADELPHIA PA 19119-3716
215-842-4225
FOX, MD, MICHAEL L IM
45 OAK AVE
LANSDOWNE PA 19050-2746
610-668-1330
FRANK, MD, LEONARD A U
1313 DEKALB ST
NORRISTOWN PA 19401-3443
610-272-1881
FRANK, MD, MARTIN N CD
1245 HIGHLAND AVE STE 308
ABINGTON PA 19001-3714
215-572-0960

FRANK, MD, PAUL E OPH
331 N YORK RD
HATBORO PA 19040-2033
215-672-0777
FRANK, MD, ROBERT L OPH
331 N YORK RD
HATBORO PA 19040-2033
215-672-0777
FRANK, DO, RONALD B FP
2026 N BROAD ST
LANSDALE PA 19446-1059
215-368-4434
FRANK, MD, TOBY L D
506 BARBARA CIR
MERION STATION PA 19066-1322
FRANKEL, MD, ARTHUR M * GS
1245 HIGHLAND AVE
ABINGTON PA 19001-3714
215-886-1020
FRANKEL, MD, LESLIE B OBG
1245 HIGHLAND AVE
ABINGTON PA 19001-3714
215-886-1234
FRAZIER, MD, THOMAS G ON
THE FOUNDERS BANK BLDG
BRYN MAWR PA 19010
610-520-0700
FREEBERG, MD, JOHN R AN
16 W. MONTGOMERY AVE APT #6
ARDMORE PA 19003-1430
610-645-2141
FREEDMAN, MD, LAWRENCE T OBG
12 FARRIER LN
BLUE BELL PA 19422-2465
215-635-2642
FREEMAN, MD, DANIAL M A CHP
721 UPSAL RD
JENKINTOWN PA 19046-3329
215-884-3568
FREIMUTH, MD, ERICH J * N
830 OLD LANCASTER RD
BRYN MAWR PA 19010
610-527-8140
FREUDENBERG, MD, DORIS T * PM
287 ANDERSON RD
KING OF PRUSSIA PA 19406-1940
610-526-3361
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408 SPRAGUE RD
NARBERTH PA 19072-1126
610-296-3333
FRIEDMAN, DO, DAVID S FP
2026 N BROAD ST
LANSDALE PA 19446-1059
215-368-4434
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BLUE BELL PA 19422
215-542-0500
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FLOURTOWN PA 19031-1214
215-248-5600
GALASSI JR, MD, JOSEPH W AN
2709 ASPEN CIR
BLUE BELL PA 19422-3401
215-662-3719
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215-657-8430
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317 AUBREY RD
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610-277-5600
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1014 MANOA RD
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142 SOMERSET RD
HUNTINGDON VLY PA 19006-6723
215-425-7029
GAZDICK, MD, MARY ANNE PD
1 RED ROWAN LN
PLYMOUTH MTNG PA 19462-2135
610-825-3500
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BRYN MAWR PA 19010
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2780 E COUNTY LINE RD
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41 ANDREW LN
LANSDALE PA 19446-1431
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353 LANKENAU MEDICAL BLDG
WYNNEWOOD, PA.19096
610-649-9021
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314 YORK ROAD
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215-884-7620
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919 E GERMANTOWN PIKE
NORRISTOWN PA 19401
610-279-1500
GILLIS, MD, ANGUS T * AN
5 MARTINS RD
NEWTOWN SQUARE PA 19073-1915
610-525-4966
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614 DEKALB ST
NORRISTOWN PA 19401-3991
610-272-3008
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1521 AMITY RD
RYDAL PA 19046-1203
215-887-3990
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610-649-0500
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BEAVER HILL S APT F-6
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HAVERFORD PA 19041
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401 CRESCENT RD
WYNCOTE PA 19095-1702
215-934-7277
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320 LANKENAU MED BLDG
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NEWTOWN SQUARE PA 19073-2506
610-272-1881
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610-667-4066
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BALA CYNWYD PA 19004-2651
215-652-8607
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GREENSPON, MD, SAMUEL E GP
8460 LIMEKILN PIKE
WYNCOTE PA 19095-2694
GROHSMAN, MD, JONATHAN M OPH
217 BARKER RD
WYNCOTE PA 19095-1715
215-576-5090
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2803 STANBRIDGE ST APT B-511
NORRISTOWN PA 19401-1630
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458 KESWICK AVE
GLENSIDE PA 19038
GUIRNALDA-CASTRO, MD,
NEMESIA G P
576 COACH RD
HORSHAM PA 19044-1613
215-225-3151
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1651 MARKLEY ST
NORRISTOWN PA 19401-2900
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ABINGTON PA 19001-3714
215-887-9690
GUYER, MD, SAMUEL GS
934 BLUE ROCK LN
BLUE BELL PA 19422-2002
HADRA, MD, ELLINOR S FP
3500 W CHESTER PIKE APT E313
NEWTOWN SQUARE PA 19073-4101
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501 N BETHLEHEM PIKE APT C4
AMBLER PA 19002-2516
HALE, MD, ROBERT G FP
4004 FAIRWAY RD
LAFAYETTE HILL PA 19444-1304
HALL, MD, NEAL E OPH
615 N MOUNT PLEASANT RD
PHILADELPHIA PA 19119-3303
HALMI, MD, BILL H * D
211 SOUTH 9TH STREET
PHILADELPHIA PA 19107
215-955-6660
HAMBURG, MD, ALLEN E ORS
532 GEORGIAN RD
GLENSIDE PA 19038-2610
HAMMOND III, MD, N LEROY * ORS
250 LANKENAU MEDICAL BUILDING
WYNNEWOOD PA 19096
610-649-3200

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1629 BRIAR HL RD
GLADWYNE PA 19035
610-642-7835
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HUNTINGDON VLY PA 19006-5009
215-576-2050
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JENKINTOWN PA 19001-1301
215-887-4130
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KING OF PRUSSIA PA 19406
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610-647-1881

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MERCK BL3-4
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LANSDALE PA 19446
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WEST NORRISTOWN PA 19403
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21 CHESWOLD DR
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LANSDALE MEDICAL GROUP
LANSDALE PA 19446-2408
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4034 WESTAWAY DR
LAFAYETTE HILL PA 19444-1533

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9 RABBIT RUN
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17 RAMSGATE CT
BLUE BELL PA 19422-2546
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1459 CONIFER DR
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23 GLEN LN
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BALA CYNWYD PA 19004-3124
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1718 BANTRY DRIVE
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SOUDERTON PA 18964-1418
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221 SINKLER DRIVE
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154 EVERGREEN CT
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WAYNE PA 19087-1357
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DANVILLE PA 17821-8565
717-271-6301
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250A LIBERTY ST
DANVILLE PA 17821
717-271-6211
RUSS, DO, SHERYL A IM
26 MEADOW LANE
DANVILLE PA 17021-9412
717-271-6211
SABOL, MD, LOUISE J OPH
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DANVILLE PA 17822-0001
717-271-8531
SARISKY-MELOY, DO, STEPHANIE FP
KNAPPER CLINIC
DANVILLE PAA 17821
717-271-6070
SCHULLER, MD, DIANE E PDA
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DANVILLE PA 17822-0001
717-271-6259
SHAH, MD, NARAYAN HEM
GEISINGER MEDICAL CTR
DANVILLE PA 17822-0001
717-271-6848
SIDOROV, MD, JAAN E IM
GEISINGER MEDICAL CTR
DANVILLE PA 17822-0001
717-271-6637
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DANVILLE PA 17822-0001
717-271-6361
SKIENDZIELEWSKI, MD, JOHN J EM
RR 6 BOX 63
DANVILLE PA 17821-8734
717-271-6812
SLEPECKI, MD, EVA M GS
4 UPPER MULBERRY ST
DANVILLE PA 17821-1139
SMITH, MD, JOSEPH L PUD
GEISINGER MEDICAL CTR
DANVILLE PA 17822-0001
717-271-6389
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DANVILLE PA 17822-0150
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DANVILLE PA 17822-0001
717-271-6139
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DANVILLE PA 17821-1770
STARKEY, MD, RALPH H END
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DANVILLE PA 17822
717-271-6028
STAYER, MD, GLENN A CHN
7 COTSWALD
DANVILLE PA 17821-8445
717-271-8254
STEEN, MD, C A EDWARD AN
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DANVILLE PA 17822
717-291-6211
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DANVILLE PA 17821-1963
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717-271-6416
TUREL JR, MD, ANTHONY P N
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TURKEWITZ, MD, DAVID PD
55 TIMBER WOOD DR
DANVILLE PA 17821-9615

VRABEC, MD, DONALD P OTO
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DANVILLE PA 17822-0001
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BLOOMSBURG PA 17815-3196
WARNER, DO, MARIE J * FP
RR 6 BOX 1
DANVILLE PA 17821-9806
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1912 RED LN
DANVILLE PA 17821-8415
717-271-8740
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587 E 5TH ST APT 2B
BLOOMSBURG PA 17815-2351
717-271-6211
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GEISINGER MEDICAL CTR
DANVILLE PA 17822-0001
717-271-6541
WOODS, MD, EDWARD L TS
GEISINGER MEDICAL CTR CVTS
DANVILLE PA 17822-0001
717-271-6211
WOOMERT, MD, CATHLEEN A DR
241 BEAGLE CLUB RD RR 8
LEWISBURG PA 17837
717-271-6301
YOUN, MD, BRIAN A CCM
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DANVILLE PA 17822
717-271-6505
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390 RED SCHOOL LN
PHILLIPSBURG NJ 08865-2230
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2690 KINGSTON RD
EASTON PA 18042-9182
610-258-0131
AHERN, MD, MARYELLEN P * AN
1875 SUNSET DR
WHITEHALL PA 18052-4140
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5610 WOOD LN
WESCOSVILLE PA 18106-9547
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EASTON PA 18042-8799
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3735 NAZARETH RD STE 302
EASTON PA 18042
610-258-2588
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BETHELEHEM PA 18018-6505
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BETHLEHEM PA 18017-7487
610-865-6044
ARNER, MD, RAYMOND H AN
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BETHLEHEM PA 18018-1649
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341 CRESENT DR
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11 N KERN DR
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2597 SCHOENERSVILLE RD
BETHLEHEM PA 18017-7330
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3311 NAZARETH RD
EASTON PA 18042-2017
610-258-6283
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1901 HAY TER
EASTON PA 18042-4850
610-252-2556
BLOSE, MD, LINDA K IM
370 S WALNUT ST
BATH PA 18017-2474
610-837-8710
BLUMENTHAL, MD, NEIL C * OBG
3580 SOUTHWOOD DR
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BETHLEHEM PA 18015-5218
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4015 LOIS LN
ALLENTOWN PA 18104-9697
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BUDURA, MD, PAUL GP
387 CARVER DR
BETHLEHEM PA 18017-4716
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312 WEDGEWOOD DRIVE
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65 E ELIZABETH AVE STE 200
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2657A SCHOENERSVILLE RD
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EASTON PA 18042-3855
CARLIN, MD, HUGH M AN
397 TIMOTHY DR
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920 PROSPECT AVE
BETHLEHEM PA 18018-5098
CHAN, MD, IAN CD
2597 SCHOENERSVILLE AVE #202
BETHLEHEM PA 18017-7330
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1115 GREENLEAF DR
BETHLEHEM PA 18017-9316
610-882-3050
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21ST AND LEHIGH STS
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4031 FREEMANSBURG AVE
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3224 WITHEE CT
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1741 DEER RUN RD
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3566 HECKTOWN RD
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782 BARRYMORE LN
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214 WEDGEWOOD RD
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3190 CHAUCER LN
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3735 EASTON NAZARETH HWY
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2775 SCHOENERSVILLE RD
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2022 QUARTER MILE RD
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TOWNSHIP LINE AND OLD YORK RD
JENKINTOWN PA 19046
215-885-1173
FORNWALT, MD, HELEN L OS
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WEST CHESTER PA 19380-5730
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PHILADELPHIA PA 19130-1729
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ARLINGTON VA 22206-1633
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PHILADELPHIA PA 19046-8097
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1914 N 63RD ST
PHILADELPHIA PA 19151-2502
FOWBLE, MD, BARBARA * R
HOSP UNIV OF PA DEPT RAD
PHILADELPHIA PA 19104-4219
215-662-3075
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701 SUMMIT AVE APT 1205
PHILADELPHIA PA 19128-2317
FOX, MD, KENNETH L PD
CHILDREN'S HOSP OF PHILA
PHILADELPHIA PA 19104
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FOX, MELISSA B ST
3431 VAUX ST
PHILADELPHIA PA 19129-1436
FOX, MD, ROBERT D D
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JENKINTOWN PA 19046
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PHILADELPHIA PA 19104
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PHILADELPHIA PA 19144-5357
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910 WELDON LN
BRYN MAWR PA 19010-2226
215-662-8134
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604 EAGLE DR
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229 W UPSAL APT 110
PHILADELPHIA PA 19119-4009
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ABINGTON PA 19001-3763
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BRYN MAWR PA 19010-4081
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PHILADELPHIA PA 19144
GAFFNEY, DANA E ST
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PHILADELPHIA PA 19107
GALLAGHER, KIMBERLY M ST
1017 SPRUCE ST APT C
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ERIE PA 16505
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PHILADELPHIA PA 19107-6008
215-829-3000
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PHILADELPHIA PA 19152-2007
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1019 EDGE HILL RD
ABINGTON PA 19001-4411
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109 MERION RD
MERION STATION PA 19066-1734
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GARCIA, MD, LAUREANO P IM
328 W GODFREY AVE
PHILADELPHIA PA 19120-1410
215-549-1100
GARCIA, MARIA M ST
3322 TILDEN ST
PHILADELPHIA PA 19129-1412
GARCIA MANERO, MD, GUILLERMO IM
834 CHESTNUT ST APT 1028
PHILADELPHIA PA 19107-5142
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PHILADELPHIA PA 19117-1517
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STE 5390 GIBBON BLDG
PHILADELPHIA PA 19107
215-955-5162
GARDNER, DO, BONNIE J END
ROWLAND HALL STE 507
PHILADELPHIA PA 19131-1810
215-871-1981
GARDNER, DO, MARSHALL K FP
15 ANTHONY DR
RICHBORO PA 18954-1328
215-969-3013
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500 E LANCASTER #101C
ST DAVIDS PA 19087-5005
GARFINKEL, MICHAEL D ST
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PHILADELPHIA PA 19130-3949
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AEMC
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215-456-6200
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5450 WISSAHICKON AVE APT 805A
PHILADELPHIA PA 19144-5219
215-848-6000
GARG, ANJU ST
3561 INDIAN QUEEN LN
PHILADELPHIA PA 19129-1539
GARG, RUCHIRA ST
4000 GYPSY LN UNIT 521
PHILADELPHIA PA 19144
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1366 REVELATION RD
MEADOWBROOK PA 19046-1022
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5515 WISSAHICKON AVE APT D204
PHILADELPHIA PA 19144-4530
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WEST CHESTER PA 19380-5712
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413 VERNON RD
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PHILADELPHIA PA 19152-3438
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34TH ST & CIVIC CTR BLVD
PHILADELPHIA PA 19104
215-590-3247
HABER, MD, HOWARD L CD
301 S 8TH ST STE 4B
PHILADELPHIA PA 19106
215-829-7900

HABER, MD, MICHELE A GER
1710 OAKWOOD TER APT 5A
PENN VALLEY PA 19072-1044
215-898-1547
HABER, MD, SHERYL A IM
317 N BROAD ST APT 504
PHILADELPHIA PA 19107-1018
HAEBERLE, MD, WILLIAM A PUD
3057 WINCHESTER AVE
PHILADELPHIA PA 19136-1805
215-831-2062
HAEGELE, MD, LINDA A * ON
1505 MONK RD
GLADWYNE PA 19035-1318
215-831-8611
HAFT, MD, HAROLD * US
460 ROCK GLEN DRIVE
WYNNEWOOD PA 19096-2619
810-284-8358
HAGAN JR, MD, EUGENE P OBG
3101 COTTMAN STREET
PHILADELPHIA PA 19149
HAGSTROM, MD, NATHAN PD
14 FLAMINGO CT
VOORHEES NJ 08043-1664
215-590-1000
HAHM, MD, JEE HO R
80 TOWNSHIP LINE RD
ELKINS PARK PA 19117-2249
215-663-6086
HAHN, MD, GREGORY V GS
3400 SPRUCE ST
PHILADELPHIA PA 19104
215-812-9838
HAIDER, MD, SYED H PD
7950 HENRY AVE APT 4A
PHILADELPHIA PA 19128-3005
215-762-7000
HAILS, MD, KEVIN C P
ALBERT EINSTEIN MED CTR
PHILADELPHIA PA 19141
215-456-7240
HAIMOWITZ, MD, JULIA E IM
APT N-1610
PHILADELPHIA PA 19130
215-662-3924
HAIMOWITZ, MD, SAMUEL I IM
1 GARDENIA RD
LEVITTOWN PA 19057-3411
215-943-2222
HAJDENBERG, MD, JULIO J IM
ROBERT WOOD JOHNSON-UMDNJ
CAMDEN NJ 08130
609-342-2000
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PHILADELPHIA PA 19104
215-590-3420
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6202 STENTON AVE
PHILADELPHIA PA 19118-2943
215-653-8012
HALL, MD, JOHN H GS
604 GENERAL SCOTT RD
WAYNE PA 19087-1310
HALL, MD, PATRICK J OTO
620 N BROAD ST
WOODBURY NJ 08096
609-848-0700
HALL, MD, ROBERT A TS
7854 DEVON ST
PHILADELPHIA PA 19118-3504
215-662-4000
HALL, MD, ROBERT H P
3940 STEVENSON ST
PHILADELPHIA PA 19114-2018
215-955-6060
HALLETT, MD, JOSEPH W OPH
191 PRESIDENTIAL BLVD APT 200
PHILADELPHIA PA 19004-1211
HALLOWELL, MD, MICHAEL J DR
24 BERKSHIRE DR
SEWELL NJ 08080
215-782-8757
HALPERN, MD, BARRY R U
1210 GAINSBORO RD
BALA CYNWYD PA 19004-2015
215-334-4420
HAMANN, MD, JOSE G P
PENNDEL MEN HLTH CTR
PENNDEL PA 19047-5707
215-752-1541
HAMILTON, CLIO A ST
701 SUMMIT AVE APT D110
PHILADELPHIA PA 19128-2313
HAMILTON, MD, RALPH W PS
3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
215-662-2046
HAMILTON, MD, WILLIAM C ORS
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PHILADELPHIA PA 19111-2432
215-745-4050
HAMILTON, MD, WILLIAM L D
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PHILADELPHIA PA 19144-2805
215-848-7600
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592F ELIZABETH DR
LANCASTER PA 17601-4406
717-291-5684

HAMPTON, REGINA M ST
7950 HENRY AVE APT 28B
PHILADELPHIA PA 19128
HAN, MD, AARON C PTH
341 RIVERVIEW RD
KING OF PRUSSIA PA 19406-2020
HAN, WON K ST
8925 FAIRFIELD ST
PHILADELPHIA PA 19152-1332
HANAU, MD, CHERYL A PTH
834 CHESTNUT ST APT 1729
PHILADELPHIA PA 19107-5150
215-955-6351
HANAWAY, MD, ANDREA S * EM
1369 KAREN LN
WAYNE PA 19087-2706
215-831-7281
HANDLER, MD, LAWRENCE F OPH
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PHILADELPHIA PA 19104
215-590-2791
HANDLER, MD, STEVEN D OTO
34TH AND CIVIC CTR BLVD
PHILADELPHIA PA 19104-4385
215-590-3454
HANES, MD, MARYANN EM
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HAVERTOWN PA 19083-5615
HANJANI, MD, PARVIZ ON
ABINGTON MEMORIAL HOSPITAL
ABINGTON PA 19001
215-885-0220
HANKINS, MD, ALTHEA IM
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PHILADELPHIA PA 19104-3414
215-842-1075
HANKS, MD, GERALD E TR
FOX CHASE CANCER CTR
PHILADELPHIA PA 19111-2430
215-728-2940
HANNA, NADINE B ST
2979 W SCHOOLHOUSE LN
PHILADELPHIA PA 19144
HANNO, MD, PHILIP M U
15 BRIARCREST DR
ROSE VALLEY PA 19086-6710
215-221-4445
HANSEN, HILARY A ST
775 TAYLOR DR
MONTEREY PARK CA 91755-6745
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226 U RITTENHOUSE SQ # 1911
PHILADELPHIA PA 19103
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4000-1118 PRESIDENTIAL BLVD
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HARDENBROOK, MITCHELL A ST
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914 SPRUCE ST APT 10
PHILADELPHIA PA 19107-6131
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100 E LANCASTER PIKE S
WYNNEWOOD PA 19096-3411
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2 BALA PLAZA STE IL-22-24
BALA CYNWYD PA 19006
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137 W GODFREY AVE
PHILADELPHIA PA 19120-1517
215-291-3645
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314 BRYN MAWR AVE
BALA CYNWYD PA 19004-2822
215-221-8496
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2814 MIDVALE AVE APT A
PHILADELPHIA PA 19129-1024
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PHILADELPHIA PA 19102-4506
215-221-3260
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649 S HENDERSON RD APT C308
KING OF PRUSSIA PA 19406-3583
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117 N 15TH ST APT 1302
PHILADELPHIA PA 19102

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HARRIS, MD, KENNETH H DR
1409 CANDLEBROOK DR
DRESHER PA 19025-1021
215-291-3630
HARRIS, MD, MARY C NPM
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PHILADELPHIA PA 19104
215-590-1653
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965 SWENLIN DR
VINELAND NJ 08360-2611
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500 WEST AVE APT B1
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12 ANN ST
WEST PITTSTON PA 18643-1702
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117 CLWYD RD
BALA CYNWYD PA 19004-2302
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708 OLD LANCASTER RD
BRYN MAWR PA 19010-3109
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PHILADELPHIA PA 19107
215-829-3544
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THE FAIRFAX APT 505
PHILADELPHIA PA 19104-2955
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321 LINDEN DR
ELKINS PARK PA 19117-1342
215-209-2460
HAWTOF, JEFFREY E ST
1938 BRANDYWINE ST APT 4
PHILADELPHIA PA 19130
HAY, BEVERLY N ST
929 LOMBARD ST #204
PHILADELPHIA PA 19147-1260
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2151 SAINT ALBERTS CIR
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111 S 11TH ST STE 4105
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295 ANDOVER PL
ROBBINSVILLE NJ 08691-9243
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PHILADELPHIA PA 19130-3221
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301 CURTIN ST
OSCEOLA MILLS PA 16666-1201
HEBERLE, DO, PAUL W ST
3960 SHAMROCK CT
ERIE PA 16510-3264
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4025 WALNUT ST APT 2-R
PHILADELPHIA PA 19104-3513
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263 HIGH RD APT C
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HEDGEPETH, CHESTER M ST
4701 PINE ST APT J-12
PHILADELPHIA PA 19143
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HAHNEMANN UNIV MAIL STP 204
PHILADELPHIA PA 19102-1101
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DOYLESTOWN PA 18901-2757

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PHILADELPHIA PA 19107-6107
HEIL, KURT M ST
1106 SPRUCE ST
PHILADELPHIA PA 15237-5222
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7900 OLD YORK RD APT 603B
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DEPT ANES AND CRITICAL CARE
PHILADELPHIA PA 19104-4385
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HEIT, MD, JEFFREY IM
INTERNATIONAL HOUSE
PHILADELPHIA PA 19104-3195
HEITMANN, MD, DEBRA W ST
602 S WASHINGTON SQ APT 602
PHILADELPHIA PA 19106
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NARBERTH PA 19072-1534
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HELLMAN, MD, ARTHUR A CDS
13 ACADIA DR
VOORHEES NJ 08043-1600
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PHILADELPHIA PA 19144-1498
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7901 HENRY AVE APT 505-A
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HENNIGAN, SHAWN P ST
8200 HENRY AVE APT A22
PHILADELPHIA PA 19128-2936
HENRETIG, MD, FREDERICK M PD
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215-590-2483
HENRY, MD, JOHN M U
431 MARKLE ST
PHILADELPHIA PA 19128-3606
215-662-2891
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THOMAS JEFFERSON UNIV
PHILADELPHIA PA 19107
215-955-6567
HERBST, MD, ALLISON B IM
5500 WISSAHICKON AVE APT 403A
PHILADELPHIA PA 19144-5638
HERBST, MD, BERNADETTE A N
1630 E HIGH ST
POTTSTOWN PA 19464-3244
HERMAN, MD, CARL D P
1200 W TABOR RD
PHILADELPHIA PA 19141-3019
215-456-9483
HERMAN, MD, HAROLD OM
803 PRESTON RD
PHILADELPHIA PA 19118-1328
215-537-4110
HERMAN, MD, JERRY H OBG
7310 CASTOR AVE
PHILADELPHIA PA 19152-4217
215-722-8880
HERMAN, MD, LEONARD Y EM
7400 ROOSEVELT BLVD APT R-201
PHILADELPHIA PA 19152-4318
215-331-8365
HERMAN, MD, WALTER M * CD
275 N LATCHES LN
MERION STATION PA 19066-1728
215-389-0600
HERMANN, JEFF W ST
3024 W QUEEN LN APT A1B
PHILADELPHIA PA 19067-4421
HERNANDEZ, MD, ENRIQUE GO
MCP 3300 HENRY AVE
PHILADELPHIA PA 19129
215-842-6937
HERNANDEZ, MD, HECTOR N OTO
2300 WALNUT ST APT 521
PHILADELPHIA PA 19103-5545
215-662-2777
HEROLD, MD, SANFORD L * GE
GERMANTOWN HOSP
PHILADELPHIA PA 19144-1498
215-844-3340
HERRERO, MD, CARMELO IM
3107 HARBOUR DR
PALMYRA NJ 08065
215-762-7000
HERRERO, MD, REBECCA L ST
3107 HARBOUR DR
PALMYRA NJ 08065
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8017 CASTOR AVE
PHILADELPHIA PA 19152-2701
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5555 WISSAHICKON AVE APT 703
PHILADELPHIA PA 19144-4540
HERRING, MD, WILLIAM R
2150 WHARTON RD
GLENSIDE PA 19038-5326
HERSH, CRAIG P ST
520 WOODLAND TER #4
PHILADELPHIA PA 19104
HERSHEY, MD, BEVERLY L R
HAHNEMANN UNIVERSITY HOSP
PHILADELPHIA PA 19102
215-762-8752
HERSHOCK, MD, DIANE M IM
2245 EDGE HILL RD
HUNTINGDON VALLEY PA 19006-5616
HERTLE, MD, RICHARD W OPH
34TH ST AND CIVIC CTR BLVD
PHILADELPHIA PA 19104
215-590-2791
HESKEL, MD, MILTON M END
60 TOWNSHIP LINE RD STE 300
ELKINS PARK PA 19117-2249
215-663-1313
HESS, MD, STEVEN G * CD
1437 HUNTINGDON RD
ABINGTON PA 19001-2103
215-537-5288
HEVEY, MATTHEW P ST
340 MEDIA STATION RD APT C227
MEDIA PA 19063-4740
HEWLETT, MD, GUY S OBG
106 S PELHAM RD
VOORHEES NJ 08043-1161
215-456-7700
HEYMAN, MD, SYDNEY NM
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PHILADELPHIA PA 19104
215-590-2587
HICKS, MD, EDWARD L P
1913 WALNUT ST STE 400
PHILADELPHIA PA 19103-4635
215-567-4122
HILL, MD, CYNTHIA A PD
1233 LOCUST ST STE 400
PHILADELPHIA PA 19107
215-545-8188
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3003 PHEASANT RD
GRANTVILLE PA 17028
HIMELSTEIN, MD, BRUCE P PHO
6460 WOODCREST AVE
PHILADELPHIA PA 19151-2407
215-590-2802
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809 JONES HALL
PHILADELPHIA PA 19140
HIRSCH, MD, IRVIN H U
1025 WALNUT ST RM 1112
PHILADELPHIA PA 19107-5001
215-928-6961
HIRSH, MD, BERNARD C * D
1420 LOCUST ST # 15F
PHILADELPHIA PA 19102-4223
215-735-8188
HLAVAC, JULIEANNE M ST
950 WALNUT ST APT 312
PHILADELPHIA PA 19107
HLAVAC, MARK A ST
175 PARKER AVE APT 1
PHILADELPHIA PA 19128
HO, MD, CHARLES C L GS
314 LODGE RD
PHILADELPHIA PA 19128
HO, LISA Y ST
1000 WALNUT ST #207
PHILADELPHIA PA 18966-4368
HOCHBERG, MD, ROBERT D DR
1119 N WOODBINE AVE
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MIAMI BEACH FL 33139-1363
HODGES, MD, JOHN H IM
436 SABINE AVE
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HOELLEIN, MD, DEBORAH E PD
7056 GERMANTOWN AVE
PHILADELPHIA PA 19119-1826
215-247-2996
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608 ABINGTON AVE
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164 SUMMIT LN
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2441 HUNTINGDON RD
HUNTINGDON VLY PA 19006-4311
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567 MANOR RD
WYNNEWOOD PA 19096-1024
215-878-6150
HOLFELNER, MD, EDWARD D U
114 THE MEWS
HADDONFIELD NJ 08033-1346
HOLLANDER, MD, ALEXIS C ST
249 GLENMORE RD
GLADWYNE PA 19035-1501
HOLLANDER, MD, BENTLEY A R
1017 DELL DR
CHERRY HILL NJ 08003-2910
302-421-4304
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1061 SUSQUEHANNA RD
RYDAL PA 19046-1822
215-338-4100
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3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
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526-A HARBOUR DR
ANDALUSIA PA 19020-7727
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HOLMAN, DAWN M ST
3120 W SCHOOLHOUSE LN
PHILADELPHIA PA 19144-5436
HOLMES, ANDREW S ST
1007 ADDISON ST
PHILADELPHIA PA 19147-1212
HOMEIER, BARBARA P ST
2922 RISING SUN RD
ARDMORE PA 19003
HONEBRINK, MD, ANN L OBG
130 VALLEY RD
ARDMORE PA 19003-1511
215-627-3670
HONET, MD, JAMES E AN
403 WOODCREST RD
WAYNE PA 19087-5412
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2209 W NORWEGIAN ST
POTTSVILLE PA 17901-1807
HOPKINS, TIM B ST
317 N BROAD ST APT 522
PHILADELPHIA PA 19107-1017
HOPP, JENNIFER L ST
1000 WALNUT ST APT 1008
PHILADELPHIA PA 19107
HOPPENFELD, BRAD M ST
712 NESHAMINY VALLEY DR
BENSALEM PA 19020-1233
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PHILADELPHIA PA 19124-2658

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KEMMERER, KELLY M ST
859 OLD LANCASTER RD APT 10A
BRYN MAWR PA 19010-3203
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415 S VAN PELT APT A3
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LODISE, MD, RAYMOND J * IM
1420 LOCUST ST STE 100
PHILADELPHIA PA 19102-4319
215-735-8459
LOFTUS, MD, THOMAS A P
278 MAPLE ST
HAWORTH NJ 07641-1122
212-288-3364
LOGAN, CAROLINE V ST
2200 BEN FRANKLIN PKWY 903E
PHILADELPHIA PA 19130
LOGAN, MD, MARTHA L IM
7661 BROOKHAVEN RD
OVERBROOK PARK PA 19151-2023
610-359-1355
LOGAN, MD, THOMAS M GP
110 MAGNOLIA DR
DOUGLASSVILLE PA 19518-1128
LOGUE, MD, JAMES G GYN
7600 PINE RD
WYNDMOOR PA 19118-2523
215-438-3301
LOHIER, MD, RAYMOND GP
1831 W CHELTENHAM AVE
PHILADELPHIA PA 19126-1028
215-276-8788
LOMAX JR, MD, WALTER P * IM
PO BOX 24
HILLTOWN PA 18927-0024
LOMBARDI, JOSEPH V ST
2508 S 17TH ST
PHILADELPHIA PA 19145-4515
LONDON, MD, PHILIP ORS
6658 SANZO RD APT B
BALTIMORE MD 21209-2442
LONDON, MD, W THOMAS IM
FOX CHASE CTR
PHILADELPHIA PA 19111-2412
215-728-2204
LONG, TRICIA A ST
5555 WISSAHICKON AVE APT 1210
PHILADELPHIA PA 19144-4545
LONGENECKER, MD, JOSEPH C IM
ABINGTON MEMORIAL HOSP
ABINGTON PA 19001
LONGNECKER, MD, DAVID E AN
UNIV OF PA DEPT ANES
PHILADELPHIA PA 19104-4283
215-662-3738
LONGO-MALLOY, DO,
DEBORAH R GP
144 GRANDVIEW RD
SPRINGFIELD PA 19064-1711
LONSDORF, MD, RICHARD G P
415 OLD GULPH RD
NARBERTH PA 19072-1442
610-664-9797
LOPEZ, MD, AISA G PM
8046 CRITTENDEN ST
PHILADELPHIA PA 19116-2909
215-233-6200
LOPONTE, MD, MARIE A TR
842 GRUBBS MILL RD
BERWYN PA 19312-1534
LORBER, MD, STANLEY H GE
211 EMERALD LN
PALM BEACH FL 33480
215-221-3433
LOUIS-CHARLES, MD, ROY PD
550 E WASHINGTON LN
PHILADELPHIA PA 19144-1011
LOVE, MD, CAROL A * FP
216 W CHELTEN AVE
PHILADELPHIA PA 19144-3803
215-848-8800
LOVE, MD, MICHAEL B DR
205 E FIEDLER RD
AMBLER PA 19002-2716
215-221-2586
LOWENSTEIN, MD, ADAM D GS
834 CHESTNUT ST APT 601
PHILADELPHIA PA 19107-5139
LOWRY, MD, LOUIS D OTO
909 WALNUT STREET
PHILADELPHIA PA 19107
215-955-6784
LU, DONG T ST
14832 HOPE ST
WESTMINSTER CA 92683
LU, MD, RONG B PD
1216 WALNUT ST APT 901
PHILADELPHIA PA 19102

LUBERTI, MD, ANTHONY A PD
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-1510
LUBIN, MD, EDWARD GS
1101 SOUTH ST APT B
PHILADELPHIA PA 19147-1956
LUBIN, MD, JOSEPH D AN
226 LOCUST ST
PHILADELPHIA PA 19106-3901
LUBIZKA, MD, ALEXANDRA P
6359 WAYNE AVE APT B1
PHILADELPHIA PA 19144-3112
215-843-9334
LUCAS, MD, R DUBOIS GP
237 E PRICE ST
PHILADELPHIA PA 19144-2147
215-438-7745
LUCAS-FEHM, MD, LYNN MICHELE R
8309 CRITTENDEN ST
PHILADELPHIA PA 19118-2913
215-247-4500
LUCEY III, MD, DENIS J US
40 W HIGHLAND AVE
PHILADELPHIA PA 19118-3310
215-247-4622
LUDOLPH, MD, CAROL ANN * NS
5049 OXFORD AVE
PHILADELPHIA PA 19124-2652
215-288-2343
LUDWIG, MD, STEPHEN PD
CHILDRENS HOSP OF PHILA
PHILADELPHIA PA 19104
215-590-2162
LUK, JOHN C ST
117 N 15TH ST #2006
PHILADELPHIA PA 19102-1520
LUM, MICHAEL H ST
29 SALMON ST
SAN FRANCISCO CA 94133
LUND, MARK E ST
530 S 2ND ST APT 627
PHILADELPHIA PA 19147-2423
LUNDY, MD, THEODORE IM
2565 E NORRIS ST
PHILADELPHIA PA 19125-3530
LUONG, JIM K ST
3026 W QUEEN LN APT B3B
PHILADELPHIA PA 19129-1057
LUONGO JR, MD, ROMEO A * OTO
2054 LOCUST ST
PHILADELPHIA PA 19103-5614
215-567-2262
LURIE, SHARI D ST
35 HAMILTON CIR
PHILADELPHIA PA 19130-3821
LUSCOMBE, MD, HERBERT A D
111 S 11TH ST
PHILADELPHIA PA 19107-4824
215-928-0212
LUSH, MD, DAVID T IM
2020 WALNUT ST APT 21B
PHILADELPHIA PA 19103-5642
215-842-6869
LUSTINE, MD, HOWARD T IM
8234 RIDGE AVE
PHILADELPHIA PA 19126-2631
LUTZ, MD, WENDY J ST
1 FRANKLIN TOWN BLVD APT 1610
PHILADELPHIA PA 19103-1285
LYNCH, MD, JAMES J GP
2316 E CUMBERLAND ST
PHILADELPHIA PA 19125-2206
MAC DONALD, MD, SARAH W PD
34 W SPRINGFIELD AVE
PHILADELPHIA PA 19116
MACCHIAVELLI, ANTHONY J ST
1825 S SARTAIN ST
PHILADELPHIA PA 19148-2113
MACDONALD, MD, JOHN S ON
3322 N BROAD ST
PHILADELPHIA PA 19140-5102
215-221-8030
MACEK, MD, ANNE L PD
532 ELLIOTT DRIVE
KING OF PRUSSIA PA 19406-1612
215-923-2583
MACFADYEN, MD, BRUCE V OBG
245 CHATHAM WAY HERSHEY MILL
WEST CHESTER PA 19380-6815
MACHT JR, MD, ELMER L GYN
3 STEEPLECHASE LN
BLUE BELL PA 19422
215-657-8430
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HUP
PHILADELPHIA PA 19104
215-662-3694
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GYPSY HILL ROAD
PENLLYN PA 19422-0035
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7922 BUSTLETON AVE
PHILADELPHIA PA 19152-3321
215-725-8500
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12 CORAL DR
CLAYMONT DE 19703-2106
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NARBERTH PA 19072-1422
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PHILADELPHIA PA 19144-3528
MACVAUGH III, MD, HORACE CDS
GRADUATE HOSP STE 901
PHILADELPHIA PA 19146
215-985-9190
MADIANOS, MD, EVAN F DR
349 S 47TH ST APT A605
PHILADELPHIA PA 19143-1863
215-717-4214
MADIANOS, MD, MICHAEL IM
2614 WOODWARD STREET
PHILADELPHIA PA 19152-1334
215-676-9223
MADONNA, MD, DINO GS
9367-B NEIL RD
PHILADELPHIA PA 19115
MADOR, MD, ANNE T PD
2227 A PRIOR RD
WILMINGTON DE 19809
MADOW, MD, LEO PYA
111 N 49TH ST
PHILADELPHIA PA 19139-2716
215-471-2339
MAENZA, MD, RONALD M PTH
805 HOLLOW RD
RADNOR PA 19087-2805
215-782-4635
MAGALSKI JR, JOSEPH J ST
4222 PECHIN ST
PHILADELPHIA PA 19128-5022
MAGARGAL, MD, HELGA O * OPH
9601 MILNOR ST
PHILADELPHIA PA 19114-3109
215-624-0500
MAGARGAL, MD, LARRY E OPH
WILLS EYE HOSP
PHILADELPHIA PA 19107
215-824-3920
MAGEE, MD, JOHN G PD
220 HEWETT RD
WYNCOTE PA 19095-1204
215-247-1172
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215-829-6502
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1251 FAIRACRES RD
JENKINTOWN PA 19046-2911
215-762-8722
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124 OLYMPUS CIR
JUPITER FL 33477-7302
MAGILNER, MARK ST
950 WALNUT ST # 606
PHILADELPHIA PA 19107-5564
MAGNUSSON, MD, MARK R PD
426 GLENDALE CIR
SPRINGFIELD PA 19064
215-590-4020
MAGRAN, MD, LEONARDO CHP
1001 VLY RD
MELROSE PARK PA 19126-1814
215-635-2482
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SCHEIE EYE INSTITUTE
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215-662-8675
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524 MAIN BLDG
PHILADELPHIA PA 19107-5244
215-955-7089
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215-590-2567
MAIER, MD, WILLIS P GS
TEMPLE UNIV HOSP
PHILADELPHIA PA 19140
215-221-3633
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111 S 11TH ST
PHILADELPHIA PA 19017
215-955-4206
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118 IVYWOOD LN
RADNOR PA 19087-2827
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7602 CENTRAL AVE STE 101
PHILADELPHIA PA 19111-2402
215-342-8330
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1015 CHESTNUT ST-STE 907
PHILADELPHIA PA 19107
215-627-1110
MAJOR, MD, DAVID A IM
824 W CLIVEDEN ST
PHILADELPHIA PA 19119-3601
215-440-8681
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225 S 18TH ST APT 915
PHILADELPHIA PA 19103-6126
MAKLER JR, MD, P TODD NM
960 MEETINGHOUSE RD
RYDAL PA 19046-2432
215-456-6280

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829 SPRUCE STREET
PHILADELPHIA PA 19066-1608
215-829-3456
MALAY, MD, MARY BETH ST
3340 HARBISON ST
PITTSBURGH PA 15212-2246
MALEK, MD, MANSOUR FP
4160 N SCOTTSDALE RD
SCOTTSDALE AZ 85251-3808
MALETA, VIVIANA M ST
257 S 16TH ST APT B13
PHILADELPHIA PA 19102-3327
MALHOTRA, MD, RITU OTO
45 N SYRACUSE DR
CHERRY HILL NJ 08034
215-955-6055
MALICKI, MARK M ST
313 S 10TH ST
PHILADELPHIA PA 19107
MALKIN, MD, ALAN G EM
1301 FAIRY HILL RD
RYDAL PA 19046-2937
215-456-6608
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9501 ROOSEVELT BLVD STE 410
PHILADELPHIA PA 19114
215-969-4917
MALKOWICZ, MD, STANLEY B U
HOSP OF UNIV OF PENNA
PHILADELPHIA PA 19010-2033
215-662-7330
MALLER, MD, ERIC S GE
CHILDRENS HOSP OF PHILA
PHILADELPHIA PA 19104
215-590-3247
MALLER, MD, JACALYN S PD
CHILDRENS HOSP OF PHILA
PHILADELPHIA PA 19104
215-590-1944
MALLOY, MD, TERRENCE R U
299 S 6TH ST
PHILADELPHIA PA 19106-4010
215-829-3409
MALMUD, MD, LEON S * NM
3401 N BROAD ST
PHILADELPHIA PA 19140-5103
215-707-7076
MAMA, MD, SAIFUDDIN T OBG
313 MEMORIAL AVE
HADDONFIELD NJ 08033
MANDAL, MD, SANAT K CD
829 SPRUCE ST STE 105
PHILADELPHIA PA 19107-5752
215-829-3530
MANDARINO, MD, MICHAEL J ORS
2832 BELMONT AVE
PHILADELPHIA PA 19131-1519
215-876-1212
MANDEL, MD, JEFFREY M OPH
216 N BROAD ST
PHILADELPHIA PA 19102
215-762-8700
MANDEL, MD, MARTIN M N
1650 HUNTINGDON PIKE STE 160
MEADOWBROOK PA 19046-8095
215-938-7730
MANDEL, MD, STEVEN * N
NEURO & NEUROPHYS ASSOC PC
PHILADELPHIA PA 19107-5115
215-574-0075
MANDELL, MD, MORTON S * CD
5401 OLD YORK RD STE 401
PHILADELPHIA PA 19141-3030
215-329-0633
MANHOFF, MD, DION T PTH
1619 MERRIBROOK LN
PHILADELPHIA PA 19151-2717
MANI, MD, SHOBHA T AN
479 ROLLING RD
ROSEMONT PA 19010-1228
MANLEY, MD, DONELSON R OPH
226 WINDSOR PL
HAVERFORD PA 19041-1823
MANLOVE, MD, FRANCIS R P
709 DIXON LN
GLADWYNE PA 19035-1601
610-649-3993
MANN, MD, BARRY D * GS
DEPT OF SURGERY
PHILADELPHIA PA 19129
215-842-7663
MANN, RONALD M ST
1938 S PARK AVE
HADDON HEIGHTS NJ 08035-1031
MANNES, MD, ANDREW J AN
519 WINDERMERE AVE
DREXEL HILL PA 19026-1117
215-662-8000
MANNESS, MD, WAYNE K DR
56 WARWICK RD
STRATFORD NJ 08084
MANNION, MD, JOHN D TS
1025 WALNUT ST
PHILADELPHIA PA 19107-5001
215-955-5095
MANNO, MD, CATHERINE S PHO
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2263
MANNO JR, MD, BRUNO V * IM
1650 HUNTINGDON PIKE STE 352
MEADOWBROOK PA 19046-8097
215-947-9216

MANSFIELD, MD, CARL M * TR
111 S 11TH ST
PHILADELPHIA PA 19107-4824
215-955-6705
MANSTEIN, MD, CARL H PS
JEANES PHYSICIAN OFFICE BLDG
PHILADELPHIA PA 19111-2431
215-742-6700
MANSTEIN, MD, GEORGE PS
1400 RYDAL RD
RYDAL PA 19046-1217
215-742-6700
MANSTEIN, MD, MARK E PS
1221 BARROWDALE RD
RYDAL PA 19046-2415
215-742-6700
MANUEL, MD, MARISTELA M IM
590 LOWER LANDING RD APT 7-B
BLACKWOOD NJ 08012
215-662-8000
MANUELL, MD, MARY-ELISE EM
834 CHESTNUT ST APT 921
PHILADELPHIA PA 19107-5141
215-955-6844
MANUS, MD, NATHAN GP
1001 CITY AVE
WYNNEWOOD PA 19096-3999
MARBACH, MD, A HERBERT GYN
CEDARBROOK HILL APTS BPH 16
WYNCOTE PA 19095-2820
MARBAN, MD, ALEX J OTO
8201 HENRY AVE APT L2
PHILADELPHIA PA 19128-2224
215-221-3689
MARCELIS, MD, JOHN F IM
2 PENN BLVD APT 202
PHILADELPHIA PA 19144-1403
215-843-8622
MARCELO, MD, FLORDELIZA S AN
872 WARFIELD LN
HUNTINGDON VLY PA 19006-2108
215-949-5336
MARCH, THERESA M ST
6 MEADOWCREEK LN
GLENMOORE PA 19343-2014
MARCHANT, MD, LEWIS K DR
5500 WISSAHICKON AVE APT 403A
PHILADELPHIA PA 19144-5698
215-893-2000
MARCHETTO, MD, PAUL A ORS
928 FIELD LN
VILLANOVA PA 19085-2003
215-221-2111
MARCOTTE, MD, PAUL J NS
HOSP OF THE UNIV OF PA
PHILADELPHIA PA 19014
215-349-8327
MARCUCCI, MD, MICHAEL C GS
227 N BROAD ST
PHILADELPHIA PA 19107-1511
215-563-5468
MARCUS, MD, DONALD K ID
60 HESTON CT
LANGHORNE PA 19047-1444
215-335-1313
MARCUS, MD, MICHAEL S AN
2911 WOODPIPE LN APT D
PHILADELPHIA PA 19129-1041
MARDEN, MD, PHILIP A OTO
3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
215-662-3363
MARGATE, MD, PEDRO R DR
CALLOWHILL OPEN MRI
PHILADELPHIA PA 19123
215-574-9400
MARGERUM, MD, BRYAN S ST
938 PENN AVE
GLENSIDE PA 19038-1924
MARGOLES, MD, LOUIS IM
7715 SYCAMORE LN
PHILADELPHIA PA 19117-1025
MARGOLIN, MD, JUDITH F PHO
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2810
MARGOLIS, MD, BERNARD PD
7342 BROOKHAVEN RD
PHILADELPHIA PA 19151-2205
215-473-8444
MARGOLIS, MD, STEPHEN H IM
CEDARBROOK HILL APTS
WYNCOTE PA 19095
215-886-6348
MARINARO, MARIA ST
4045 DEXTER ST
PHILADELPHIA PA 19128-5219
MARINO, ALLEN T ST
2200 BEN FRANKLIN PKWY
PHILADELPHIA PA 19130-3601
MARINO, LOUIS C ST
313 S 10TH ST
PHILADELPHIA PA 19107
MARINO, MD, RALPH PM
111 S 11TH ST
PHILADELPHIA PA 19106-4109
215-955-5012
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934 COATES RD
MEADOWBROOK PA 19046-2542
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MARR, BRIAN P ST
118 YARMOUTH LN
MEDIA PA 19063-4329

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PHILADELPHIA PA 19130-1722

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153 MEDFORD LEAS
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113 N MOLE ST
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PHILADELPHIA PA 19106-4212
215-922-2920

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MERION STATION PA 19066-1613

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PHILADELPHIA PA 19107-5127

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2400 CHESTNUT ST APT 610
PHILADELPHIA PA 19103-4315

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63 LANKENAU MED BLDG E
WYNNEWOOD PA 19096
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1118 SANDRINGHAM RD
BALA CYNWYD PA 19004-2023
215-762-8389

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PHILADELPHIA PA 19144

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834 CHESTNUT ST APT 1203
PHILADELPHIA PA 19107-5143

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PUGLISI, MD, ANTHONY S ORS
7201 RISING SUN AVE
PHILADELPHIA PA 19111-3926
215-742-6303
PUGLISI, MD, VINCENT GP
3900 GALT OCEAN DR APT 2716
FORT LAUDERDALE FL 33308
PULLEN, DO, CARL R FP
5922 GREENE ST
PHILADELPHIA PA 19144-2727
PUPPALA, SHAYM ST
1110 OLDE HICKORY RD
LANCASTER PA 17601-4938
PURCELL, SUSAN M ST
1100 SPRUCE ST APT 3-D
PHILADELPHIA PA 19107
PYFER, MARK F ST
UNIVERSITY OF PA
PHILADELPHIA PA 19104
QAYYUM, MD, IMRAN PD
701 SUMMIT AVE APT D-211
PHILADELPHIA PA 19128-2324
QUALLS, MD, DONALD M ORS
218 LANKENAU MED BLDG S
WYNNEWOOD PA 19096
610-649-7590
QUINN, MD, GRAHAM E OPH
PEDIATRIC OPHTHALMOLOGY
PHILADELPHIA PA 19104
215-590-2791
RABER, MD, IRVING M OPH
LANKENAU MED BLDG STE 156
WYNNEWOOD PA 19096
215-699-7000
RABINOVICI, MD, REUVEN * GS
777 PERIWINKLE LN
WYNNEWOOD PA 19096-1647
215-955-4138
RABINOWITZ, MD, HOWARD K PD
26 LIBERTY LN
CHERRY HILL NJ 08002-1638
215-955-7416
RABSON, MD, MOSES ORS
1133 ASHBOURNE RD
CHELTENHAM PA 19012-1108
RACKOW, MD, LAWRENCE L A
BEAVER HILL APT B-26
JENKINTOWN PA 19046
RAD, BABAK N ST
400 W HORTTER ST # 406
PHILADELPHIA PA 19119-3640
RADBILL, MD, SIDNEY G OPH
41 CONSHOHOCKEN STATE RD
BALA CYNWYD PA 19004-2426
RADECKI, MD, PAULA J OBG
750 LEWIS LN
AMBLER PA 19002-5144
215-662-7840
RADON, PAULA A ST
3097 N 5TH ST
WHITEHALL PA 18052-3123
RADOSH, LEE J ST
1321 LOMBARD ST
PHILADELPHIA PA 19147
RAFEI, KEYVAN ST
5450 WISSAHICKON AVE APT 612A
PHILADELPHIA PA 19144-5297
RAFFENSPERGER, MD,
BRUCE W GYN
717 BETHLEHEM PIKE
PHILADELPHIA PA 19118-2111
215-233-3331
RAFFERTY, DO, MICHAEL F FP
101 MORELAND RD
HUNTINGDON VALLEY P 19006-7944
215-464-9000

RAGONESI, MD, SUSAN B * PD
101 CLYMER CT
PHILADELPHIA PA 19147
215-755-4640
RAINES, MD, HERBERT S GP
6897 N 19TH ST
PHILADELPHIA PA 19126-1534
RAINES, MD, JONATHAN M P
PO BOX 470
GLADWYNE PA 19035-0470
610-649-8717
RAJASEKHARA, PADMA ST
8 ALLEGHENY CTR STE 623
PITTSBURGH PA 15212-5232
RAJASENAN, KIRAN K ST
117 N 15TH ST APT 806
PHILADELPHIA PA 19102-1516
RAJTER, JEAN-JACQUES ST
3120 W SCHOOLHOUSE LN
PHILADELPHIA PA 19144-5444
RAKINIC, MD, JAN CRS
604 S WASHINGTON SQ APT 703
PHILADELPHIA PA 19106-4115
215-923-5010
RALPH, MD, NATHAN PUD
7400 ANNAPOLIS LN
PARKLAND FL 33067-1634
305-755-2477
RALSTON, MD, EDGAR L ORS
3300 DARBY RD APT 3315
HAVERFORD PA 19041-1070
RAM, MD, NAND IM
22 ASHBROOKE DR
VOORHEES NJ 08043-2817
215-787-9356
RAMACIOTTI, MD, CLAUDIO PDC
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-1792
RAMAN, MD, JAYALAXMI PD
900 RONNIE CIR
PHILADELPHIA PA 19128-1045
215-848-0888
RAMDIAL, MD, HORACE L NPM
1025 WALNUT ST
PHILADELPHIA PA 08053-4226
215-955-6523
RAND, MD, ELIZABETH B PD
CHILDREN'S HSPTL OF PHILA
PHILADELPHIA PA 19104
215-590-3077
RANDALL, MD, JOHN L FP
1015 WALNUT ST RM 401
PHILADELPHIA PA 19107-5005
215-955-7272
RANDALL, MD, PETER * PS
3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
215-662-2042
RANIERI, DO, JOSEPH N IM
2234 S CHADWICK ST
PHILADELPHIA PA 19132-3852
RANIERI, MD, TITO A GS
2320 S BROAD ST
PHILADELPHIA PA 19145-4417
215-462-7373
RANUCCI-WEISS, MD, DENISE A OBG
1023 CLINTON ST
PHILADELPHIA PA 19107-6016
215-221-2000
RAO, MD, VIJAY M DR
132 S 10TH ST
PHILADELPHIA PA 19107
215-955-4804
RAPHAELY, MD, RUSSELL C AN
CHILDRENS HOSP
PHILADELPHIA PA 19104
215-590-1672
RASCOE JR, MD, ROBERT R OBG
3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
215-386-9090
RASEFSKE, JASON P ST
3516 BOWMAN ST
PHILADELPHIA PA 19129
RASHID, MD, MOHAMMAD IM
10825 E KESWICK RD APT 93
PHILADELPHIA PA 19154-4124
215-427-7000
RASHKIS, MD, HAROLD A P
10 CONSHOHOCKEN STATE RD
GLADWYNE PA 19035-1328
610-649-2511
RATNER, MD, ERIC R AN
111 S 11TH ST STE 66460
PHILADELPHIA PA 19107
215-855-6161
RAVANDOOST, MD, PARVANEH FP
220 E MERMAID LN APT 118
PHILADELPHIA PA 19118-3207
215-844-1020
RAVETZ, PAMELA C ST
7409 RICHARDS RD
MELROSE PARK PA 19126-2025
RAVETZ, DO, ROBERT S * P
1919 CHESTNUT ST APT 924
PHIALDELPHIA PA 19103-3414
215-831-4701
RAVIOLA, MD, CAROL ANN VS
301 S 8TH ST STE 2-A
PHILADELPHIA PA 19106-4014
215-829-6520

RAY, ANDREA O ST
221 S 12TH ST APT 613-S
PHILADELPHIA PA 19107-5556
RAY, MD, TARUN K END
609 ASHBOURNE RD
ELKINS PARK PA 19117-2518
215-221-3560
RAYBECK-DE VLIEGER, KELLI J ST
5219 RIDGE AVE
PHILADELPHIA PA 19128-3711
RAZDAN, MD, BHARTI NPM
100 FULMER DR
VOORHEES NJ 08043
215-590-1650
READ, MD, FRANK P
1 FRANKLIN TOWN BLVD APT 405
PHILADELPHIA PA 19103
215-456-7890
REDDY, MD, GAYATRI P IM
1000 WALNUT ST APT 1306
PHILADELPHIA PA 19107
215-762-7000
REDDY, MD, RAVICHANDRA PM
546 BASILICA CIRCLE
PHILADELPHIA PA 19128-1915
REED, MD, CRYSTAL D TR
3826 SHARP ST
PHILADELPHIA PA 19127-1616
REED, MD, KRISTYN M IM
217 E SEDGWICK ST
PHILADELPHIA PA 19119-1807
REED, SCOTT F ST
1801 JFK BLVD APT 802
PHILADELPHIA PA 19102
REEDY, MD, BRIAN K GS
4521 LARCHWOOD AVE
PHILADELPHIA PA 19143-2105
215-662-4000
REES, MD, CHRISTOPHER J IM
1700 PINE STREET
PHILADELPHIA PA 19103-6702
215-829-3358
REEVE, AMANDA D ST
1 VIRGINIA AVE
WESTMONT NJ 08108
REFFINO PEREYRA, MD, MARIA R GS
317 N BROAD ST APT 308
PHILADELPHIA PA 19107-1015
REICHARD, MD, PETER S AN
275 BRYN MAWR AVE APT E-43
BRYN MAWR PA 19010-4026
215-662-3727
REID-ARTIST, MD, JACINTH M PM
3120 W SCHOOL HOUSE LN # FB10
PHILADELPHIA PA 19144-5444
REILLY, JOHN P ST
600 W HARVEY ST APT A712
PHILADELPHIA PA 19144
REINACH, MD, ALAN J IM
159 N 3RD ST APT 3 S
PHILADELPHIA PA 19106-1914
REINECKE, MD, ROBERT D * OPH
WILLS EYE HOSP
PHILADELPHIA PA 19107
215-928-3149
REINHARD, MD, DAVID L PM
532 CYNWYD CIR
BALA CYNWYD PA 19004-2523
215-349-8370
REINPRECHT, MD, JAMES T IM
6190 RISING SUN AVE
PHILADELPHIA PA 19111-6011
215-725-8114
REIS, MD, GREGG J CD
801 SPRUCE ST
PHILADELPHIA PA 19107-5701
215-829-5064
REISCHEL, MD, ULRICH A EM
1111 LOMBARD ST
PHILADELPHIA PA 19147
REISH, TIMOTHY G ST
5500 WISSAHICKON AVE
PHILADELPHIA PA 19144
REISINGER, MD, SUSAN A TR
DEPT OF RADIATION ONCOLOGY
PHILADELPHIA PA 19107
215-955-6045
REISS III, MD, G RUSSELL GS
317 S 13TH ST
PHILADELPHIA PA 19107-5917
REITANO, MD, JOHN P
1726 GREEN ST APT 2
PHILADELPHIA PA 19130-3912
215-662-3513
REITER, MD, DAVID FPS
PO BOX 770
NARBERTH PA 19072-0770
215-955-8682
REITER, GEORGE T ST
2024 GREEN ST APT D
PHILADELPHIA PA 19130-3209
REITER, MD, SEAN B DR
317 N BROAD ST APT 617
PHILADELPHIA PA 19107-1017
RESNICK, MD, ALBERT B P
7764 MELLON RD
WYNCOTE PA 19095-2319
215-924-3423
RESNICK, MD, EDWARD J ORS
TEMPLE UNIV HOSP
PHILADELPHIA PA 19140
215-707-8486

RESNICK, MD, GEORGE J CD
2236 S 20TH ST
PHILADELPHIA PA 19145-3527
RESURRECCION, MD, ROSARIO AN
ANAESTHESIA DEPT
PHILADELPHIA PA 19141
215-456-6850
REYNOSO, MD, ZORAIDA L IM
7172 MIDWAY AVE
UPPER DARBY PA 19082-4923
215-662-8000
REZNAK, MD, STEPHEN E * N
1514 WOLF ST
PHILADELPHIA PA 19145-4449
215-463-3029
RHAUDA, PATRICIA P ST
10 HAMILTON CIR
PHILADELPHIA PA 19130-3822
RHEINBOLT, MD, RICHARD M PD
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-1510
RHOA, MD, MATTHEW F OBG
2323 NAUDAIN ST
PHILADELPHIA PA 19146-1119
215-662-6035
RHOADS SR, MD, JONATHAN E GS
3400 SPRUCE ST 4TH FL
PHILADELPHIA PA 19104-4220
215-662-2008
RIBEN, MICHAEL W ST
1738 LOMBARD ST
PHILADELPHIA PA 19146-1519
RICCHETTI, MD, ROBERT J PD
9140 ACADEMY RD
PHILADELPHIA PA 19114-2853
RICE, MD, GEORGE E PTH
834 CHESTNUT ST APT PH209
PHILADELPHIA PA 19107-5127
215-829-3543
RICHARDSON, MD, DAVID W N
1008 TANNERIE RUN RD
AMBLER PA 19002-4015
215-387-3401
RICHARDSON, MD, PAUL A * DR
2007 DELANCEY PL
PHILADELPHIA PA 19103-6509
610-254-8480
RICHERTS, MD, JOSEPH L CD
7901 BUSTLETON AVE STE 200
PHILADELPHIA PA 19152-3302
215-332-4000
RICHMAN, MD, KENNETH A * AN
1 GRADUATE PLZ
PHILADELPHIA PA 19146-1407
215-893-2184
RICHMOND, MD, ALLEN C OPH
KNIGHTS AND RED LION RDS
PHILADELPHIA PA 19114
215-824-1717
RIED, MD, STEPHANIE R PD
CHILDRENS SEASHORE HOUSE
PHILADELPHIA PA 19104
RIGG, MD, L ISOBEL P
725 BEACON LN
MERION STATION PA 19066-1603
610-660-9670
RILEY, DO, JUDITH A IM
1700 CLAIR MARTIN PL
AMBLER PA 19002-6002
215-787-9000
RINCON-VERACOECHEA, MD,
GUNTHER A US
3400 RED LION RD APT 9F
PHILADELPHIA PA 19114-1397
215-612-4000
RISH, MD, BENITO B PS
11-56 JACKSON AVE
SCARSDALE NY 10583
914-968-0404
RITCHIE, MD, DAVID J R
442 WILLIAMS RD
WYNNEWOOD PA 19096-2012
RITCHIE III, MD, JOHN C P
315 N LANSDOWNE AVE
LANSDOWNE PA 19050-1017
610-259-9995
RITTER, MD, CHARLES W AN
102 PINE VALLEY DR
MEDFORD NJ 08055-9214
RITTER, MD, DEBORAH E AN
102 PINE VALLEY DR
MEDFORD NJ 08055-9214
RIVAS, MD, STEVEN * IM
1 FRANKLINTOWN BLVD APT 507
PHILADELPHIA PA 19103-1285
RIVIELLO, MD, RALPH J ST
71 LOCUST RIDGE DR APT 1-D
PITTSBURGH PA 15208-2071
RIZVI, MD, SYED ASIF R END
3322 N BROAD ST
PHILADELPHIA PA 19141
215-221-4545
RIZZO, MARCO ST
8100 HENRY AVE APT 5F
PHILADELPHIA PA 19128
ROBBINS, MD, ELIZABETH L PD
1233 LOCUST ST STE 400
PHILADELPHIA PA 19107
215-427-5000
ROBBINS, MD, INGA H OTO
3 FAIRHAVEN RD
HAVERTOWN PA 19083-5719
610-645-2000

ROBBINS, KENT C ST
4233 BROOKVIEW PL
ELKINS PARK PA 19117-2910
ROBBINS, MD, MARK S HEM
1907 S BROAD ST
PHILADELPHIA PA 19148-2218
215-334-3787
ROBBINS, MD, ROBERT TR
253 STANISH RD
MERION STATION PA 19066-1133
ROBBINS, MD, WILLIAM S P
222 SPRINGHOUSE LN
MERION STATION PA 19066-1115
610-667-5721
ROBERTO, MD, PAUL J GS
4000 PRESIDENTIAL BLVD # 1223
PHILADELPHIA PA 19131-1722
ROBERTS, MD, ANDREW B * VS
3300 HENRY AVE
PHILADELPHIA PA 19129-1121
215-842-6533
ROBERTS, MD, BROOKE * GS
8208 SHEAFF LN
FT WASHINGTON PA 19034-1819
215-662-2025
ROBERTS, MD, JOAN M OBG
9840 GERMANTOWN AVE
CHESTNUT HILL PA 19118-2725
215-248-4186
ROBERTS, MD, JOHN M GS
234 W ALLENS LANE
PHILADELPHIA PA 19119-4138
215-242-4700
ROBERTS, MD, STEVEN A OTO
2201 SAGEMORE DR
MARLTON NJ 08053-4314
215-662-8000
ROBERTSON, MD, JOHN W GS
1335-49 TABOR RD STE 109
PHILADELPHIA PA 19141
ROBINSON, MD, CLAIRE E B OBG
5301 KNOX ST
PHILADELPHIA PA 19144-6215
610-664-8725
ROBINSON, MD, FREDERICK A IM
180 FOXCATCHER LN
MEDIA PA 19063-1104
ROBINSON, MD, KEVIN G CD
7500 CENTRAL AVE STE 102
PHILADELPHIA PA 19111
215-745-2333
ROBINSON, MD, MURRAY D * NS
1330 POWELL ST STE 504
NORRISTOWN PA 19401
610-270-0199
ROBINSON, MD, NATHANIEL M GER
5229 SPRUCE ST
PHILADELPHIA PA 19139-4022
ROBY, MD, DAVID S * N
7500 CENTRAL AVE
PHILADELPHIA PA 19111-2431
215-725-4804
ROCCO, MD, MARTIN J * AN
8TH AND SPRUCE STS
PHILADELPHIA PA 19147-1404
215-829-5588
ROCCO, MD, NICHOLAS J IM
2202 S BROAD ST
PHILADELPHIA PA 19107
RODGERS, MD, DAVID M * CD
1722 BETHLEHEM PIKE
FLOURTOWN PA 19031-1844
215-233-9700
RODGERS, MD, FLORENCE E IM
1347 ANTHONY WAYNE DR
WAYNE PA 19087-1350
RODGERS, MD, JOSEPH F IM
211 S 9TH ST STE 4187
PHILADELPHIA PA 19107-5506
215-955-6614
RODGERS, MD, TIMOTHY J * IM
958 COUNTY LINE RD
BRYN MAWR PA 19010-2502
610-527-5751
RODRIGUEZ, MD, DAISY A IM
52 W MAPLE AVE
BOUND BROOK NJ 08805-1734
908-458-1717
RODRIGUEZ, MD, GEORGE L PM
1320 RACE ST 2ND FLR
PHILADELPHIA PA 19107
215-567-3088
RODRIGUEZ, MD, RAYMOND CD
1722 BETHLEHEM PIKE
FLOURTOWN PA 19118-2816
215-247-9400
ROEDDER, MD, SUSAN L EM
6306 FARWAR LANE
FLOURTOWN PA 17031-1308
215-836-2410
ROESER, MD, WINDI M IM
426 FITZWATER ST
PHILADELPHIA PA 19147-3109
215-221-2660
ROGERS, MD, JAMES F GP
5300 CEDAR AVE
PHILADELPHIA PA 19143-1918
ROGERS, MD, R CLAUDE PM
161 HIGHLAND CIR
BALA CYNWYD PA 19004-2909
ROITMAN, MD, HARRY B GYN
463 N HIGHLAND AVE
MERION STATION PA 19066-1709

ROJAS, MD, JOB F PD
628 SPRING LN
PHILADELPHIA PA 19128-1046
215-482-4790
ROLING, DANIEL B ST
2001 HAMILTON ST APT 1820
PHILADELPHIA PA 19130
ROLLE JR, MD, WILLIAM A US
7829 RUGBY ST
PHILADELPHIA PA 19150-2509
ROMANOFF, MD, DAVID IM
1112 HAGYSFORD RD
PENN VALLEY PA 19072-1102
215-878-5600
ROMANOW, MD, PETER W ORS
PO BOX 55
FAIRLESS HILLS PA 19030-0055
215-945-4795
ROMY, MD, MAURICE NS
THE SPINE CENTER
PHILADELPHIA PA 19103-4342
215-665-8330
RONEN, ALON ST
21 SHELTON CT
COMMACK NY 11725
RONIS, MD, MAX L OTO
3400 N BROAD ST
PHILADELPHIA PA 19140-5104
215-221-3685
ROSATO, MD, ERNEST F GS
UNIV OF PA
PHILADELPHIA PA 19104-4220
215-662-2033
ROSATO, MD, FRANCIS E GS
1025 WALNUT ST
PHILADELPHIA PA 19107-5001
215-955-8643
ROSCOE, MD, CONSTANTINE PD
229 BROOKSIDE DR
FEASTERVILLE PA 19053-6308
ROSE, BRUCE T ST
3325 PARK AVE
PHILADELPHIA PA 19140
ROSE, MD, DAVID I ATP
834 CHESTNUT ST APT 1619
PHILADELPHIA PA 19107-5148
ROSE, DOUGLAS J ST
208 S STATE RD APT 2
UPPER DARBY PA 19082
ROSE, MD, ELIZABETH K PD
KENDAL #1
KENNETT SQUARE PA 19348
ROSE, HARRY J ST
325 N 15TH ST APT 1108
PHILADELPHIA PA 19102
ROSE, MD, HENRY S DR
1199 WATERWHEEL DR
PHILADELPHIA PA 19067-4551
215-291-3647
ROSE, MD, LESLIE I END
230 N BROAD ST
PHILADELPHIA PA 19102-1121
215-762-8114
ROSE, MD, LEWIS J HEM
111 S 11TH ST STE 6185
PHILADELPHIA PA 19107-4824
215-923-5676
ROSEMOND, MD, GEORGE P * GS
825 OLDE HICKORY RD APT 100
LANCASTER PA 17601-4957
ROSEN, MD, DAVID OTO
241 S 6TH ST APT 2002
PHILADELPHIA PA 19106-3734
215-955-8055
ROSEN, MD, DAVID IM
2375 WOODWARD ST APT 112
PHILADELPHIA PA 19115-5121
215-676-4947
ROSEN, MD, ILENE M IM
226 W RITTENHOUSE SQ APT 814
PHILADELPHIA PA 19103-5796
ROSEN, MD, JOSEPH H R
470 BALLYTORE RD
WYNNEWOOD PA 19096-2309
ROSEN, MD, MARC R OTO
130 TRIANON LN
VILLANOVA PA 19085-1441
215-829-5180
ROSEN, MD, MARVIN I GYN
CEDARBROOK HILL APTS B-709
WYNCOTE PA 19095
215-885-8887
ROSEN, MD, SHARON I ST
834 CHESTNUT ST #1105
PHILADELPHIA PA 19107
ROSENBAUM, MD, ARMAND L GS
2039 GULF OF MEXICO DR G3-108
LONGBOAT KEY FL 34228-3252
215-867-3417
ROSENBAUM, MD, CARL A IM
11903 BUSTLETON AVE
PHILADELPHIA PA 19116-2513
215-464-0770
ROSENBERG, MD, HENRIETTA K * PDR
ALBERT EINSTEIN MED CTR
PHILADELPHIA PA 19141-3098
215-456-6200
ROSENBERG, MD, HENRY * AN
322 SYCAMORE AVE
MERION STATION PA 19066-1539
215-782-7962

ROSENBERG, MD, IRVING CRS
1225 FAIRY HILL RD
JENKINTOWN PA 19046-2923
215-342-0977
ROSENBERG, MD, KENNETH C * CD
111 S 11TH ST STE G6120
PHILADELPHIA PA 19107-4824
215-923-5255
ROSENBERG, MD, MANUEL IM
7500 CENTRAL AVE STE 105
PHILADELPHIA PA 19111-2434
215-742-0712
ROSENBERG, MD, MORTON PD
8823 PATTON RD
WYNDMOOR PA 19118-1433
610-397-2336
ROSENBERG, MD, PAUL E D
1015 CORN CRIB DR
HUNTINGDON VLY PA 19006-3305
215-757-0800
ROSENBERG, MD, RANDY M N
727 WELSH RD
HUNTINDON VLY PA 19006-6357
215-947-8239
ROSENBERG, MD, ROBIN E CRS
9892 BUSTLETON AVE STE 206
PHILADELPHIA PA 19115-2184
215-673-0343
ROSENBLUM, MD, MINDY F PD
101 MAPLE AVE
BALA CYNWYD PA 19004-3016
610-668-4680
ROSENBLUM, MD, NORMAN G OBG
830 PRIMROSE LANE
WYNNEWOOD PA 19096-1664
610-649-8085
ROSENOW JR, MD, EDWARD C IM
3300 DARBY RD
HAVERFORD PA 19041-1061
ROSENTHAL, MD, DAVID E IM
1726 CLINTON DR
AMBLER PA 19002-2445
215-885-8550
ROSENTHAL, MD, PHILIP * NS
1550 FLAT ROCK RD
NARBERTH PA 19072-1238
215-457-3322
ROSENWASSER, MD, ROBERT H NS
3401 N BROAD ST
PHILADELPHIA PA 19107
215-221-4067
ROSENZWEIG, MD, MAX GP
337 ROBINSON DR
BROOMALL PA 19008-3724
ROSETT, MD, JEFFREY S FP
2375 WOODWARD ST STE 102-06
PHILADELPHIA PA 19115
215-677-6400
ROSIN, MD, DEBORAH F OTO
1720 OAKWOOD TER APT 7C
NARBERTH PA 19072-1045
215-662-2777
ROSKIN, ROBERT E ST
4618 PINE ST
PHILADELPHIA PA 19143-1808
ROSKOS, MD, STEVEN E ST
1009 E WALNUT ST
LANCASTER PA 17602
ROSNER, MD, ISADOR K IM
GREENHILL CONDO APT ED428
WYNNEWOOD PA 19096
ROSS, MD, DENISE H * GER
1939 FAWN DR
LAVEROCK PA 19118-1229
215-473-7511
ROSS, MD, R DOUGLAS OBG
HAHNEMANN UNIV MS404
PHILADELPHIA PA 19102-1192
215-762-1784
ROSSBERG, MD, MARK I AN
34TH & CIVIC CTR BLVD
PHILADELPHIA PA 19104
215-590-1858
ROSSMAN, MD, RONALD E ON
1919 CHESTNUT ST
PHILADELPHIA PA 19103-3401
215-561-5490
ROTH, MD, JAMES L GE
567 HICKORY LN
BERWYN PA 19312-1434
215-222-5490
ROTH, MD, JONATHAN V * AN
5501 OLD YORK ROAD
PHILADELPHIA PA 19141-3098
215-456-6850
ROTH, MD, KATALIN E IM
700 SPRUCE ST
PHILADELPHIA PA 19106-4014
215-829-3521
ROTH, MD, TONI C DR
1500 LOCUST ST APT 3116
PHILADELPHIA PA 19102-4321
215-762-8742
ROTHKOPF, MD, BRAD M CD
6231 OLD YORK RD
PHILADELPHIA PA 19141-2014
215-824-4411
ROTHKOPF, MD, HENRY IM
6231 OLD YORK RD
PHILADELPHIA PA 19141-2014
215-824-4411

ROTHMAN, MD, RICHARD H ORS
800 SPRUCE ST
PHILADELPHIA PA 19107-6130
215-829-3458
ROTHSTEIN-RUBIN, MD, RENE ON
619 CHAUNCEY RD
PENN VALLEY PA 19072-1303
215-662-5947
ROTTENBERG, DO, LOUIS GP
1631 FAWN LN
HUNTINGDON VLY PA 19006-7917
215-332-3931
ROUSE, MD, PAUL V U
96 BUCKS MEADOW LN
NEWTOWN PA 18940-1406
ROVINSKY, DAVID ST
3904 SPRUCE ST
PHILADELPHIA PA 19104-4113
ROWAN, MD, PHILIP T OTO
241 S 6TH ST APT 2205
PHILADELPHIA PA 19106-3735
ROWE, MD, LEE D OTO
2340 E ALLEGHENY AVE
PHILADELPHIA PA 19134-4433
215-423-6670
ROWMAN, MD, LEO GP
5325 OLD YORK RD
PHILADELPHIA PA 19141-2912
ROXBY, MD, BRUCE S IM
411 N MIDDLETOWN ROAD
MEDIA PA 19063-4435
215-482-6682
ROY, MD, DIPANWITA PD
1003 BROWNING PL
WARMINSTER PA 18974-3807
215-426-5566
ROY, MD, JOHN AN
1947 PRESTON AVE
WILLOW GROVE PA 19090-3026
ROY, MD, PRAVEEN K US
10625 E KESWICK RD APT 233
PHILADELPHIA PA 19154-4133
215-612-4000
ROYER, CHRISTIAN T ST
950 WALNUT ST
PHILADELPHIA PA 19107
ROZANSKI JR, MD, LAWRENCE T CD
PEPPER PAVILLION STE 101
PHILADELPHIA PA 19146
215-893-2495
RUBIN, DO, CARL S DR
FRANKFORD HOSP
PHILADELPHIA PA 19114
215-612-4020
RUBIN, MD, EMANUEL PTH
1020 LOCUST ST STE 279
PHILADELPHIA PA 19107-6731
RUBIN, MD, I EDWARD OPH
255 S 17TH ST FL 1509
PHILADELPHIA PA 19103-6215
215-561-0251
RUBIN, MD, JONATHAN D DR
371 MAPLEWOOD AVE
MERION STATION PA 19066
215-893-2041
RUBIN, MD, JOYCE R IM
1427 VINE ST
PHILADELPHIA PA 19102-1031
215-782-6950
RUBIN, MD, WALTER IM
3300 HENRY AVE
PHILADELPHIA PA 19129-1121
215-842-6957
RUBIN-DE CELIS, MD, CARLOS US
10625 E KESWICK RD APT 4
PHILADELPHIA PA 19154-4129
215-612-4000
RUBINSON, ERIK S ST
8923-A EARLY APRIL WAY
COLUMBIA MD 21046
RUDDY, MD, PATRICK J AN
3548 CALUMET ST
PHILADELPHIA PA 19129-1602
RUDLEY, MD, LLOYD D P
UNIV HOSP OF PA
PHILADELPHIA PA 19139-2716
215-471-2820
RUDNICK, MD, HERMAN D P
6806 CASTOR AVE
PHILADELPHIA PA 19149-2106
215-342-6900
RUDOLPH, MD, JOSEPH PYA
270 WILTSHIRE
WYNNEWOOD PA 19096
610-664-0670
RUDZINSKI, MD, AMY J AN
317 N BROAD #404
PHILADELPHIA PA 19107-1015
610-447-2000
RUFFER, MD, JAMES E TR
9032 AYRDALE CRESCENT
PHILADELPHIA PA 19128
215-662-3694
RUGART, MD, KARL F OBG
301 S 8TH ST STE 3-G
PHILADELPHIA PA 19106-4014
215-922-6234
RUGEL, MD, STANLEY J IM
337 GRIBBEL RD
WYNCOTE PA 19095-1107
215-455-1216

RUGGLES, CRAIG S ST
20411 VENUS CIR
HUNTINGTON BEACH CA 92646
RUNK, MD, LORENZO G * N
1514 WOLF ST
PHILADELPHIA PA 19145-4449
215-463-3029
RUSCZYK, GREGG E ST
317 N BROAD ST APT 313
PHILADELPHIA PA 19107-1015
RUSSO, MD, KATHLEEN ST
3461 MIDVALE AVE
PHILADELPHIA PA 19129-1405
RUSSO, MD, PIERANTONIO TS
FRONT ST AND ERIE AVE
PHILADELPHIA PA 19134
215-427-5109
RUSSO-STIEGLITZ, MD,
KAREN E OBG
900 PINE ST APT 1R
PHILADELPHIA PA 19107-6128
RUTBERG, MD, FRANKLIN L OTO
20 CONSHOHOCKEN STATE ROAD
BLA CYNWYD PA 19004-3335
RUTBERG, MD, MICHAEL GS
2 PENN BLVD STE 117
PHILADELPHIA PA 19144-1402
215-849-7580
RUTENBERG, MD, HAROLD L CD
700 SPRUCE ST FL 504
PHILADELPHIA PA 19106-4027
215-829-3344
RUTH, MD, COREY K * ORS
520 S 19TH ST 3RD FL
PHILADELPHIA PA 19146-1449
215-985-1772
RUTSTEIN, MD, RICHARD M PD
419 MEADOW LN
MERION STATION PA 19066-1332
215-590-2168
RUTTENBERG, MD, BERTRAM A CHP
315 BERKLEY RD
MERION STATION PA 19066-1403
610-667-4150
RUTTENBERG, DO, NORMAN F R
FRANKFORD AND WAKELING STS
PHILADELPHIA PA 19124
215-934-4020
RYAN, MD, JOHN L * IM
8217 ARDMORE AVE
WYNDMOOR PA 19118-2401
610-834-2558
RYAN, MD, KATHLEEN F IM
4000 PRESIDENTIAL BLVD #1101
PHILADELPHIA PA 19131-1720
215-448-7000
RYCHIK, MD, JACOB PDC
404 GARY LN
BALA CYNWYD PA 19004-2701
SABILI, MD, ERLINDA A IM
3427 BRIGHTON ST
PHILADELPHIA PA 19149-2007
215-456-6000
SABOL, MD, CAROLYN L OPH
55 RAMPART DR
WAYNE PA 19087
215-928-3000
SABUGO, MD, EVELYN F PD
9972 WOODFERN RD
PHILADELPHIA PA 19115-2011
215-426-1220
SACHDEVA, MD, AJIT K GS
3300 HENRY AVE
PHILADELPHIA PA 19129-1121
215-842-6582
SACHS, MD, MARVIN L IM
3400 SPRUCE ST
PHILADELPHIA PA 19104-4219
215-386-7416
SADEL, KEITH E ST
1723 GRIFFITH ST APT 2
PHILADELPHIA PA 19111-2903
SADWIN, MD, ARNOLD N
313 S 17TH ST
PHILADELPHIA PA 19103-6726
215-735-1363
SAFABAKHSH, NAHEED ST
1023A JONES HALL
PHILADELPHIA PA 19101
SAFABAKHSH, MD, SAIED IM
625 E LANCASTER AVE APT C302
WYNNEWOOD PA 19096-2017
610-896-0223
SAFDAR, MD, AAMIR P
7841 RIDGE AVE APT 212
PHILADELPHIA PA 19128-3044
215-762-8140
SAFFORD, SHAWN D ST
3808 HAMILTON ST
PHILADELPHIA PA 19104-2316
SAFINA, DO, THOMAS E AN
4321 MAIN ST APT 3F
PHILADELPHIA PA 19127-1533
215-221-3505
SAGALOW, MD, BARRY R DR
106 BENTLEY DR
MOUNT LAUREL NJ 08054-4501
215-934-4020
SAGEMAN, MD, MARC S P
200 LOCUST ST APT 15A
PHILADELPHIA PA 19106-3916
215-862-4000

SAGER, MD, ETHEL P
18 SUTPHIN PNES
YARDLEY PA 19067-3461
SAHL, MD, HENRY G CD
C/O M SAHL
PHILADELPHIA PA 19102-4210
215-726-3700
SAINI, MD, SUNIL K PD
2201 PENNSYLVANIA AVE APT 812
PHILADELPHIA PA 19130-3518
SAITO, NAOYUKI G ST
2020 WALNUT ST APT 15-M
PHILADELPHIA PA 19103-5640
SAJJADIAN, MD, ALI GS
4000 PRESIDENTIAL BLVD
PHILADELPHIA PA 19131-1798
SAKOLSKY, DARA J ST
701 SUMMIT AVE APT C5
PHILADELPHIA PA 19128-2323
SALAK, MD, WASYL W GS
7033 SHEAFF LN
FT WASHINGTON PA 19034-2017
SALEH, MD, A NABIL * PTH
RR 3 BOX 360
PHILIPSBURG PA 16866-9558
814-342-6236
SALEHI, HASSAN A ST
562 HURON AVE
CAMBRIDGE MA 02138-4640
SALERNO, MD, DENISE A PD
2400 CHESTNUT ST APT 712
PHILADELPHIA PA 19103-4315
SALES, MD, IRVING J GP
04102400084E APT 302
MERION STATION PA 19066
SALES, MD, PHOENIX M OBG
2480 PRESIDENTIAL WAY
W PALM BEACH FL 33401-1354
SALKIND, MD, GENE Z NS
1601 WALNUT ST
PHILADELPHIA PA 19102-2909
215-843-8908
SALNER, MD, NATHAN P R
13 SNOWDEN RD
BALA CYNWYD PA 19004-2632
SALTZER, KAREN R ST
3600 CHESTNUT ST BOX 719
PHILADELPHIA PA 19104
SALTZMAN, MD, MARCUS B OS
59 MILLSTONE LN
WILLINGBORO NJ 08046-2916
810-768-3615
SALVAGE, MD, ROBERT H AN
777 W GERMANTOWN PIKE
PLYMOUTH MTNG PA 19462-1031
215-951-8941
SALVATORE, MD, DONALD E PD
8201 HENRY AVE APT L8
PHILADELPHIA PA 19128-2227
215-427-5170
SALVO, MD, PAUL J GP
1830 S BROAD ST
PHILADELPHIA PA 19145-2393
SALZANO, LAURA J ST
378 FOREST AVE
GLEN RIDGE NJ 07028-1908
SALZMAN, DO, GARY R GP
5945 LANSDOWNE AVE
PHILADELPHIA PA 19151-3932
215-878-4585
SAMHOURI, MD, FAROUQ A VS
2137 WELSH ROAD STE 1C
PHILADELPHIA PA 19115
215-969-3944
SAMM, PAUL L ST
1919 MT VERNON ST
PHILADELPHIA PA 19130
SAMPATH, MD, KRISHNA PD
6044 CASTOR AVE
PHILADELPHIA PA 19454-3660
215-535-0900
SAMPATHACHAR, MD,
KAKKADASAM R AN
6366 SHERWOOD RD
PHILADELPHIA PA 19151-2518
610-237-4280
SAMUELS, MD, PAULINE M IM
2134 S 68TH ST
PHILADELPHIA PA 19142-1232
SANDERS, MD, MELINDA E ST
950 WALNUT ST APT 415
PHILADELPHIA PA 19107
SANDLER, LEONARD L ST
BLYTHEWOOD APTS #E34E
PHILADELPHIA PA 19144
SANDLER, MD, MATTHEW J OTO
530 S 2ND ST APT 636
PHILADELPHIA PA 19147-2423
215-762-7000
SANDO, MD, RALPH S OPH
100 CHURCH RD MEDICAL BLDG
ARDMORE PA 19003-2316
610-649-7616
SANDOVAL-BARRETT, MD,
JESSY C P
1510 POWDERMILL LN
WYNNEWOOD PA 19096-2615
SANGRIGOLI, MD, RENEE A IM
9021 AYRDALE CRESCENT BOX D9
PHILADELPHIA PA 19128-1048
SANTA MARIA II, RICHARD G ST
1 FRANKLIN TOWN APTS #610
PHILADELPHIA PA 19103

SANTANGELO, MD, MARSHA F GS
336 KNOLL RD
NORRISTOWN PA 19401-2210
SANTILLI, MD, THOMAS F CD
1415 LORIMER AVE
HUNTINGDON VLY PA 19006-8111
717-947-5971
SANTMAN, MARK ST
9217 BLUE GRASS RD APT 8
PHILADELPHIA PA 19114-4327
SANTORA, MD, THOMAS A GS
3300 HENRY AVE
PHILADELPHAI PA 19129-1121
215-842-6567
SANTORO, MD, JEROME * ID
LANKENAU MED BLDG E STE 467
WYNNEWOOD PA 19096
810-896-0210
SAPONARO, MD, STEPHEN A DR
52 BLUEJAY DR
CLEMENTON NJ 08021-5625
SAPPERSTEIN, SCOTT B ST
NY03 PARKTOWNE PLACE
PHILADELPHIA PA 19130
SARAFIAN, STEPHEN R ST
2036 RACE ST APT #3R
PHILADELPHIA PA 19103
SARAGOVI, MD, ARMAND A R
60 TOWNSHIP LINE RD
ELKINS PARK PA 19117-2249
215-663-6069
SARIEGO, MD, JOAQUIN GS
928 CALENDONIA ST
PHILADELPHIA PA 19128-1128
215-782-8175
SARIN, MD, LOV K OPH
LANKENAU MED STE 160
WYNNEWOOD PA 19096
810-896-0768
SARKAR, MD, SHYAMAL IM
PRESBYTERN UNIV OF PA
MED CTR
PHILADELPHIA PA 19104-2692
215-662-8000
SARKESSIAN, DO, ALBERT M GP
6412 RISING SUN AVE
PHILADELPHIA PA 19111-5229
215-457-7777
SARSHIK, MD, MILTON PD
527 FOXCROFT SQ APT
JENKINTOWN PA 19046
215-247-2986
SASSO, MD, PHILIP J AN
THOMAS JEFFERSON UNIV HOSP
PHILADELPHIA PA 19147-1032
215-955-6181
SATALOFF, MD, DAHLIA M GS
34 LODGES LN
BALA CYNWYD PA 19004
215-735-4699
SATALOFF, MD, JOSEPH OTO
1721 PINE ST
PHILADELPHIA PA 19103-6701
215-545-3322
SATALOFF, MD, ROBERT T * OT
1721 PINE ST
PHILADELPHIA PA 19103-6701
215-545-3322
SATCHELL, JACQUELINE R ST
229 EDGEWOOD AVE
NEW HAVEN CT 06511-4104
SATO, MD, TAKAMI PD
611 CREEKSIDE LN
WALLINGFORD PA 19086-6952
215-955-8875
SATTERLY, CLYDE H ST
3331 INDIAN QUEEN LN
PHILADELPHIA PA 19129-1519
SAUCO, MD, M CONCEPCION OBG
ANDORRA SHOPPING CTR
PHILADELPHIA PA 19128-2199
SAUL, MD, ALBERT CD
3425 MANOR RD
HUNTINGDON VLY PA 19006-4118
215-271-5300
SAUL, MD, LEON J P
275 HIGHLAND AVE
MEDIA PA 19063-2205
SAULL, MD, SONDRA C OTO
8101 FENTON RD
LAVEROCK PA 19118-1141
215-288-2102
SAVACOOL, MD, JACOB W IM
519 FORT WASHINGTON AVE
FT WASHINGTON PA 19034-1544
SAVAGE, MD, MICHAEL P CD
THOMAS JEFFERSON UNIV
HOSPITAL
PHILADELPHIA PA 19048-2818
215-955-6476
SAVINO, MD, PETER J OPH
WILLS EYE HOSPITAL
PHILADELPHIA PA 19107
215-928-3130
SAVIT, MD, RUSS M DR
725 LAWSON AVE
HAVERTOWN PA 19083-4109
215-782-8747
SAWYER, MD, JEFFREY R GS
UNIVERSITY OF PENNSYLVANIA
PHILADELPHIA PA 19104

SAWYER, MD, MICHAEL A J GS
121 EVAC DEPT OF SURGERY
APO AP 96205
011-822-7917
SAYEN, MD, JOHN J CD
1127 PENN TOWER
PHILADELPHIA PA 19104-4211
215-662-2880
SCACHERI, MD, JENNIFER E IM
327 GASKILL ST
PHILADELPHIA PA 19147-1511
SCACHERI, MD, ROBERT Q OBG
327 GASKILL ST
PHILADELPHIA PA 19147-1511
SCANLIN, MD, THOMAS F PD
CHILDRENS HOSP OF PA
PHILADELPHIA PA 19104
215-590-3749
SCARANO, MD, VICTOR R PDS
2020 WALNUT STREET
PHILADELPHIA PA 19103-5637
215-568-7771
SCHAFER, MD, CHARLES H GS
2701 HOLME AVE STE 104
PHILADELPHIA PA 19152-2029
215-563-5468
SCHAFFER, MD, DAVID B OPH
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2791
SCHAFFER, MD, DAVID W AN
2601 HOLME AVE STE 201
PHILADELPHIA PA 19152-2007
215-335-6213
SCHAFFER, MD, LILLY H IM
4040 PRESIDENTIAL BLVD
PHILADELPHIA PA 19131-1727
215-662-3924
SCHAINKER, MD, BRUCE A PTH
FRANKFORD HOSP
PHILADELPHIA PA 19114
215-612-4036
SCHALLER, MD, JAMES L P
30 LINWOOD AVE
ARDMORE PA 19003-2815
215-842-4192
SCHATANOFF, MD, JOSEPH DIA
829 SPRUCE ST
PHILADELPHIA PA 19107-5752
215-574-9550
SCHATZ, MD, NORMAN J N
200 OCEAN LANE DR APT 305
KEY BISCAYNE FL 33149-1419
215-928-3130
SCHECKER, MD, NEIL H P
UNIV HOSP OF PA
PHILADELPHIA PA 19139-2798
215-471-2505
SCHEINER, ADAM J ST
81 MEADOWBROOK RD
RANDOLPH NJ 07869-3856
SCHELLENBERG, MD, JOSEPH B IM
3901 CONSHOHOCKEN AVE APT 830
PHILADELPHIA PA 19131-5498
SCHER, MD, CHARLES D ON
34TH & CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2022
SCHERR, MD, STUART A * OTO
8020 CASTOR AVE
PHILADELPHIA PA 19152-2732
215-722-4111
SCHIFFMAN, MD, RAYMOND J PTH
497 FERN AVE
CHERRY HILL NJ 08034-3140
215-829-3545
SCHILLER, MD, HERBERT M GP
311 HAWS LN
PHILADELPHIA PA 19118-1021
215-483-4300
SCHILLING, MARIA M ST
3723 CALUMET ST 1ST FL
PHILADELPHIA PA 19129
SCHIMMER, MD, BARRY M RHU
818-824 PINE ST STE 1-C
PHILADELPHIA PA 19107
215-829-5358
SCHINDLER, MD, ALAN M PD
3219 W PENN ST
PHILADELPHIA PA 19129-1017
215-844-1701
SCHLAFF, MD, LILLIAN T PH
414 NEWBOLD RD
JENKINTOWN PA 19046-2851
SCHLAFF, MD, SHELDON IM
330 SOUTH NINTH STREET
PHILADELPHIA PA 19107
215-829-3391
SCHLEIFER, MD, CHARLES R NEP
LANKENAU HOSP
WYNNEWOOD PA 19096
610-649-1175
SCHLERNITZAUER, AMY R ST
4701 PINE ST APT D13
PHILADELPHIA PA 19143
SCHLESINGER, MD, ROBERT B CD
1 GRADUATE PLZ STE 101
PHILADELPHIA PA 19146-1407
215-893-2495
SCHLESSEL, MD, RICHARD B CHP
7701 DORCAS ST
PHILADELPHIA PA 19111-2824
215-953-6100

SCHLEZINGER, MD, NATHAN S N
WYNCOTE HOUSE
WYNCOTE PA 19095-1408
SCHLICHTING, MD, CHRISTINE M AN
200 CARPENTER ST
PHILADELPHIA PA 19147-4221
215-427-5220
SCHLOSSBERG, MD, DAVID ID
DIR INT MED EPISCOPAL HOSP
PHILADELPHIA PA 19125
215-427-7068
SCHMIDHEISER, MD, MARK A ST
RR 2 BOX 427-F
MULLICA HILL NJ 08062
SCHMIDT, MD, COURTLAND M OPH
LANKENAU MED OFF BLDG STE 154
WYNNEWOOD PA 19096
810-649-9800
SCHMIDT, MD, RICHARD J OTO
700 SCOTT LN
WALLINGFORD PA 19086-6735
215-955-6760
SCHMIDT JR, MD, ERWIN R ORS
3400 SPRUCE ST
PHILADELPHIA PA 19104
SCHMITT, SUSAN C ST
1911 BRANDYWINE
PHILADELPHIA PA 19130-3202
SCHMUKLER, DO, ANITA G P
1001 CITY AVE APT WB1012
WYNNEWOOD PA 19096-3942
SCHNALL, MD, BARRY PM
1350 WARNER RD
MEADOWBROOK PA 19046-2536
215-233-2810
SCHNALL, MD, CHARLES IM
1215 MANOA RD
WYNNEWOOD PA 19096-3325
810-649-9289
SCHNALL, MD, DAVID J PD
3896 PINE RD
HUNTINGDON VLY PA 19006-2306
SCHNALL, MD, NATHAN OBG
7310 CASTOR AVE
PHILADELPHIA PA 19152-4217
215-722-8880
SCHNAUFER, MD, LOUISE PDS
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2733
SCHNEEBERG, MD, ARTHUR L U
60 TOWNSHIP LINE RD RM 315
ELKINS PARK PA 19117-2249
215-379-3777
SCHNEEBERG, MD, NORMAN G END
MADISON HOUSE STE D103
PHILADELPHIA PA 19131
215-477-3300
SCHNEIDER, MD, BERNARD OPH
1726 S BROAD ST STE 101
PHILADELPHIA PA 19145-2321
215-463-3400
SCHNEIDER, MD, JAN OBG
3300 HENRY AVE
PHILADELPHIA PA 19129-1121
215-842-7183
SCHNEIDER, MD, LAWRENCE H HS
901 WALNUT ST
PHILADELPHIA PA 19107-5211
215-629-0980
SCHNEIMAN, MD, MAURICE H P
561 MEADOWBROOK RD
HUNTINGDON VLY PA 19006-6862
215-947-9080
SCHNUR, MD, RHONDA E D
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2189
SCHRAMM, MD, CRAIG M PDP
610 HOMESTEAD AVE
HAVERTOWN PA 19083-2638
215-590-3749
SCHRAUDENBACH, COOPER C ST
325 N 15TH ST #813C
PHILADELPHIA PA 19102
SCHREINER, MD, MARK S PD
CHILDRENS HOSPITAL OF PHILA
PHILADELPHIA PA 19104-4385
215-590-1857
SCHROEDER, MD, JEROME S * DR
8201 HENRY AVE APT E5
PHILADELPHIA PA 19128-2924
215-456-7890
SCHULMAN, MD, EDWARD S PUD
HAHNEMANN UNIVERSITY HOSP
PHILADELPHIA PA 19102
215-448-8011
SCHULMAN, MD, ELLIOTT A N
1 PENN BLVD
PHILADELPHIA PA 19144-1407
215-951-8926
SCHULMAN, MD, SETH L PD
34TH AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-2449
SCHULTZ, MD, CHRISTOPHER F GE
50-56 N FRONT ST APT 206
PHILADELPHIA PA 19106-2219
SCHULTZ, MD, JULIUS IM
7804 GAYLE RD
CHELTENHAM PA 19012-1006
215-831-0585

SCHULTZ, MD, NEIL R PM
7901 HENRY AVE APT D405
PHILADELPHIA PA 19128-3068
215-707-7022
SCHULTZE, MD, ROBERT L ST
807 CLOVER CT
MURRYSVILLE PA 15668
SCHURICHT, MD, ALAN L GS
800 SPRUCE ST
PHILADELPHIA PA 19107
215-955-6864
SCHUSTER, MD, ALBERT H U
255 S 17TH ST
PHILADELPHIA PA 19103-6231
215-545-3672
SCHUT, MD, LUIS NS
3107 W COULTER AVE
PHILADELPHIA PA 19129-1001
215-590-2780
SCHUTTE, MD, SHARON L GP
1900 RITTENHOUSE SQ
PHILADELPHIA PA 19103-5735
215-955-6175
SCHWAB, MD, MORTON E P
255 S 17TH ST
PHILADELPHIA PA 19103-6231
215-735-3394
SCHWAB, MD, ROBERT H CD
2401 PENNA AVE STE 1A2
PHILADELPHIA PA 19130-3061
215-763-2323
SCHWALB, MD, ALLEN J AN
GRADUATE HOSP
PHILADELPHIA PA 19146-1497
215-893-2187
SCHWALB, MD, NEIL S P
FRIENDS HOSP
PHILADELPHIA PA 19124
215-831-4803
SCHWAMM, MD, HARRY A PTH
104 ATLEE CIR
BERWYN PA 19312-2069
215-893-2240
SCHWARTZ, MD, ALAN J * AN
1000 SHARPLESS RD
MELROSE PARK PA 19126-1818
215-842-6798
SCHWARTZ, MD, BARRY J P
214 GSB-BARCLAY BLDG
BALA CYNWYD PA 19004
610-667-6399
SCHWARTZ, MD, ELIAS PD
CHILDREN'S HOSP OF PHIA
PHILADELPHIA PA 19104
215-590-3571
SCHWARTZ, MD, EMANUEL E DR
775 PARKES RUN LN
VILLANOVA PA 19085-1132
SCHWARTZ, MD, GORDON F ON
1015 CHESTNUT ST STE 510
PHILADELPHIA PA 19107-4305
215-627-8487
SCHWARTZ, MD, HARRY W PM
MOSS REHAB HOSP
PHILADELPHIA PA 19141-3019
215-456-9495
SCHWARTZ, MD, LINDEN M PM
2020 WALNUT ST 18-F
PHILADELPHIA PA 19103
215-456-9495
SCHWARTZ, MD, LOUIS GP
921 S 3RD ST
PHILADELPHIA PA 19147-4206
215-389-3131
SCHWARTZ, MD, M WILLIAM PD
CHILDRENS HOSP
PHILADELPHIA PA 19104
215-662-6390
SCHWARTZ, MD, MARC L CD
2020 WALNUT ST #8L
PHILADELPHIA PA 19103-5637
215-955-8706
SCHWARTZ, NADINE ST
7740C STENTION AVE #304
PHILADELPHIA PA 19118-3151
SCHWARTZ, MD, RAYMOND CD
615 OAK SHADE AVE
ELKINS PARK PA 19117-1713
215-634-5595
SCHWARTZ, MD, ROBERT P OBG
2 PENN BLVD STE 203
PHILADELPHIA PA 19144-1403
215-849-1359
SCHWARTZ, MD, STEPHEN L * P
307 LAMPLIGHTER LN
HUNTINGDON VLY PA 19006-3034
215-955-6503
SCHWARTZMAN, GREGORY J ST
2762 CRAWSTON RD
PHILADELPHIA PA 19131-2804
SCHWARZ, MD, DONALD F PD
34TH CIVIC CTR BLVD
PHILADELPHIA PA 19104
215-590-2195
SCHWARZ, MD, GABRIEL A N
195 INLETS BLVD
NOKOMIS FL 34275-4113
215-699-4209
SCOLA, DO, FILOMENA M ST
711 S SCHELL ST
PHILADELPHIA PA 19147-2035

SCOPELLITI, DEBRA ST
8201 HENRY AVE APT O-20
PHILADELPHIA PA 19128-2983
SCOTT, MD, EARL S US
962 FRAZIER RD
RYDAL PA 19046-2408
215-887-2466
SCOTT, MD, H DENMAN IM
215 SUNRISE LN
PHILADELPHIA PA 19118-3933
215-351-2830
SCOTT, MD, HENRY GP
1109 ROCK CREEK
WYNCOTE PA 19080-2013
SCOTT, KIRBY J ST
2565 CRUM CREEK DR
BERWYN PA 19312-2111
SCOTTI, MD, DANIEL M DR
METHODIST HOSP
PHILADELPHIA PA 19148-3594
215-952-9152
SCRIBNER, MD, BRENDA C P
PO BOX 14960
PHILADELPHIA PA 19149-0960
215-955-8420
SEAVER, MARK A ST
7841 RIDGE AVE APT B-250
PHILADELPHIA PA 19128
SEDACCA, MD, PAUL J IM
2300 S BROAD ST
PHILADELPHIA PA 19145-4417
215-463-2100
SEGAL, MD, BERNARD L CDS
PHILADELPHIA CARDIOLOGY ASSOC
PHILADELPHIA PA 19104
215-662-5050
SEGAL, MELISSA A ST
2118 PINE ST 1ST FLR
PHILADELPHIA PA 19103-6535
SEGAL, MD, SCOTT IM
2025 LONGSHORE AVE
PHILADELPHIA PA 19149-1616
610-528-3000
SEGAL, MD, STANTON IM
34TH ST AND CIVIC CENTER BLVD
PHILADELPHIA PA 19104
215-590-3372
SEID, DERICE P ST
216 ST MARKS SQ
PHILADELPHIA PA 19104-3517
SEIN, MD, PHYU P P
7676 SPRING AVE APT 4A
ELKINS PARK PA 19117-2633
SEINIGE, MD, URSULA L GS
19TH AND LOMBARD STS STE 901
PHILADELPHIA PA 19146
215-735-4699
SEITCHIK, MD, MURRAY W PS
THE YORKTOWN COURTYARD
ELKINS PARK PA 19117
215-572-6888
SEITCHIK, MD, SCOTT H AN
257 BIRCH DR
LAFAYETTE HILL PA 19444-2103
SEITZ JR, MD, HORACE M OBG
214 AIRDALE RD
ROSEMONT PA 19010-1645
215-662-3244
SEKERES, MIKKAEL A ST
1512 SPRUCE ST BOX 176
PHILADELPHIA PA 19102
SEKULA-PERLMAN, MD,
ADRIENNE PTH
2518 PINE ST
PHILADELPHIA PA 19103-6421
215-823-7474
SELBST, MD, STEVEN M PD
CHILDRENS HOSPITAL
PHILADELPHIA PA 19104
215-590-1944
SELBY, RACHEL M ST
3352 VAUX ST
PHILADELPHIA PA 19129-1530
SELCER, MD, UZI M PD
647 HERMITAGE ST
PHILADELPHIA PA 19128-2605
215-456-7890
SELICKMAN, MD, MITCHELL A GER
3020 SUMMERVILLE APT 1004
PHILADELPHIA PA 19141
SELIG, MD, ROBERT M * PD
ANDORRA PEDIATRICS
PHILADELPHIA PA 19128-2028
215-483-8558
SELINGO, MD, JAMIE A IM
834 CHESTNUT ST APT 1115
PHILADELPHIA PA 19107-5143
SELLERS, MD, ALFRED M CD
718 ARLINGTON RD
NARBERTH PA 19072-1503
215-662-2883
SELTZER, MD, JOSEPH L AN
1025 WALNUT ST
PHILADELPHIA PA 19107-5001
215-928-7182
SEMBROT, MD, WILLIAM B IM
921 PLYMOUTH RD
NORRISTOWN PA 19401-2527
215-823-7821
SEMPOWSKI, DO, TIMOTHY J AN
408 W WALNUT ST
NORTH WALES PA 19456-3325
215-456-7890

SENGSTAKEN, MD, ELIZABETH A FP
1015 WALNUT ST STE 401
PHILADELPHIA PA 19107-5099
215-955-7272
SERBER, MD, WILLIAM TR
7301 COVENTRY RD APT 407
MELROSE PARK PA 19126-2408
610-278-2510
SERGOTT, MD, ROBERT C OPH
900 WALNUT ST
PHILADELPHIA PA 19107
215-928-3130
SEROTA, DO, BENJAMIN GP
1420 LOCUST ST APT 15A
PHILADELPHIA PA 19102-4290
SERRANO, MD, ALBERTO C P
PHILA CHILD GUIDANCE CTR
PHILADELPHIA PA 19104-4322
215-243-2830
SERRIAN JR, MD, JOHN L IM
350 E WILLOW GROVE AVE # 213
PHILADELPHIA PA 19118-4413
215-456-6013
SETH, MD, RAJENDRA N CD
820 HILTON LN
PHILADELPHIA PA 19117-1210
215-831-7000
SETZENFAND, MD, ROY A ST
406 MARZOLF RD
PITTSBURGH PA 15209-1100
SEY, MD, MARK J PD
6608 CASTOR AVE
PHILADELPHIA PA 19149
215-342-7711
SEYEDZADEH, MICHELLE ST
8201 HENRY AVE APT P-5
PHILADELPHIA PA 19128
SGRO, MD, ANTONIO FP
301 CHATHAM ROAD
TURNERSVILLE NJ 08012-1056
SHABLIN, BRIAN K ST
7001D MCCALLUM ST
PHILADELPHIA PA 19119-3038
SHACKLETT, MD, DOROTHY E IM
CLARA BURK NURSING HOME APT 4
PLYMOUTH MTNG PA 19462
SHAFIA, MD, HASS IM
3401 W SCHOOL HOUSE LN
PHILADELPHIA PA 19144-5419
215-438-0104
SHAH, AMIT R ST
325 N 15TH ST APT 1509A
PHILADELPHIA PA 19102
SHAH, ASIT K ST
1317 TANGLEWOOD DR
NORTH WALES PA 19454-3667
SHAH, HIREN M ST
2020 WALNUT ST APT 18-A
PHILADELPHIA PA 19103
SHAH, MD, JITENDRA N PD
7519 TORRESDALE AVE
PHILADELPHIA PA 19136-3335
215-335-2220
SHAH, MD, MAHENDRA C * IM
206 PEEL RD
LANGHORNE PA 19047-8203
215-423-2481
SHAH, MD, SHAILEN R AI
1426 EDGEVALE RD
WYNNEWOOD PA 19096-3808
215-955-6504
SHAH, MD, SUSIE S IM
834 CHESTNUT ST #1107
PHILADELPHIA PA 19107-5142
SHANAHAN, MD, J RUSH RHU
RR 2 BOX 73B
HONEYBROOK PA 19344-9226
SHANGOLD, MD, MONA M REN
HAHNEMANN UNIV
PHILADELPHIA PA 19102
215-762-6866
SHAPIRO, MD, AARON L OTO
1516 SPRUCE ST
PHILADELPHIA PA 19102
SHAPIRO, MD, BARBARA S PD
333 EXETER RD
DEVON PA 19333-1709
215-590-3748
SHAPIRO, MD, BERNARD * NM
417 HIDDEN RIVER RD
NARBERTH PA 19072-1112
215-456-6260
SHAPIRO, MD, LEONARD H OBG
117 S 17TH ST 10TH FL
PHILADELPHIA PA 19103-5114
215-561-1224
SHAPREN, KRISTEN M ST
487 HARDMAN LN
WARMINSTER PA 18974-5269
SHARE, MD, FREDERICK S R
3341 STONE BOAT RD
FT LAUDERDALE FL 33312
305-835-6173
SHARE, LISA J ST
7955 ALGON AVE 1ST FL
PHILADELPHIA PA 19111-2817
SHARIFF, MD, HAJI M VS
333 N OXFORD VALLEY RD
FAIRLESS HILLS PA 19030-2605
215-943-5166
SHARIFI-AZAD, MD, SAID AN
3 COLLAGE COURT
CHERRY HILL NJ 08003
215-955-6181

SHARPS, MD, FRANK GP
930 MONTGOMERY AVE APT 106
ROSEMONT PA 19010-3037
SHAVER, MD, ELLEN G NS
320 S SAINT BERNARD ST
PHILADELPHIA PA 19143-1617
215-662-3489
SHAW, MD, CAROLYN C OBG
2230 E ALLEGHENY AVE
PHILADELPHIA PA 19134
215-739-9740
SHAW, DAVID J ST
1 FRANKLINTOWN BLVD APT 1519
PHILADELPHIA PA 19103
SHAW, MD, KATHY N PD
CHILDRENS HOSP-DEPT PED
PHILADELPHIA PA 19104
215-590-1944
SHAWALUK, MD, PAUL D * OPH
6751 AKRON ST
PHILADELPHIA PA 19149-2329
SHECTER, DO, FREDRIC M CHP
245 OLD LANCASTER AVE
BALA CYNWYD PA 19004-2932
610-667-4888
SHEETS, MD, EVERETT O FP
3158 COTTMAN AVE
PHILADELPHIA PA 19149-1501
215-338-6381
SHEETS, KIMBERLY R ST
3948 PINE ST APT A-1
PHILADELPHIA PA 19104
SHEIKH, EMRAN S ST
1000 WALNUT ST APT 1800
PHILADELPHIA PA 19107-5521
SHEINBAUM, MD, ROY J AN
111 S 11TH ST STE 524 MAIN
PHILADELPHIA PA 19107-5092
215-955-616
SHELANSKI, MD, SHARON L AI
710 MILL CREEK RD
GLADWYNE PA 19035-1521
610-649-9300
SHELTON, MD, BARBARA * PM
2 INDEPENDENCE PL STE 2101
PHILADELPHIA PA 19106-3756
215-625-0800
SHEN, R ROY ST
1125 SPRUCE ST #3F
PHILADELPHIA PA 19107
SHENKIN, MD, HENRY A NS
3300 DARBY RD
HAVERFORD PA 19041-1069
SHEPPS, CRAIG D ST
834 CHESTNUT ST #1626
PHILADELPHIA PA 19107-5148
SHER, MD, LIANE PM
6 FRANKLIN PLZ
PHILADELPHIA PA 19102-1177
215-587-3066
SHER, MD, PAUL B IM
401 E MAIN ST
MILLVILLE NJ 08332-5355
609-825-5700
SHER, PETER M ST
246 W UPSAL ST APT F-103
PHILADELPHIA PA 19119
SHER, MD, SCOTT A AN
8502 ALICIA ST 1ST FL
PHILADELPHIA PA 19111-1302
SHERBOTIE, MD, JOSEPH R NEP
CHILDREN'S HOSPITAL
PHILADELPHIA PA 19104
215-590-2449
SHERK, MARY H ST
624 SPRUCE ST
PHILADELPHIA PA 19106-4114
SHERMAN, MD, ANTHONY IM
700 SPRUCE ST
PHILADELPHIA PA 19106-4027
215-829-6767
SHERMAN, CAROLYN E ST
2108 GREEN ST
PHILADELPHIA PA 19130-3111
SHERMAN, MD, M JACKSON OTO
100 S BERKLEY SQ APT 10 G
ATLANTIC CITY NJ 08401
SHERWIN, MD, ROBERTA IM
301 THIRD ST AT WEST AVE
OCEAN CITY NJ 08226
609-399-6055
SHETH, MD, VIRAL R CD
429B SHAWMONT AVE
PHILADELPHIA PA 19128-4033
215-955-6060
SHIEH, JOSEPH T C ST
515 S 10TH ST UNIT G
PHILADELPHIA PA 19147-1253
SHIELDS, MD, JERRY A OPH
9TH AND WALNUT STS
PHILADELPHIA PA 19107
215-928-3105
SHIENBAUM, ALAN J ST
191 PRESIDENTIAL BLVD # 815
BALA CYNWYD PA 19004-1235
SHIH, HENRY T ST
3600 CHESTNUT ST BOX 0837
PHILADELPHIA PA 19104
SHILLING, MD, JACK W ST
14 CHEVY CHASE
HERSHEY PA 17033

SHILOH, AARON O ST
320 WOODLAND TERRACE APT 4
PHILADELPHIA PA 19104
SHIMER, RICHARD T ST
3518 SUNNYSIDE AVE
PHILADELPHIA PA 18049-4213
SHIN, BRIAN J ST
APT 1803 PARK TOWNE EAST
PHILADELPHIA PA 19130
SHIN, EDWARD J ST
2400 CHESTNUT ST APT 305
PHILADELPHIA PA 19103
SHIN, SOON K ST
6100 HENRY AVE #4C
PHILADELPHIA PA 19128-1504
SHINNICK, DO, JAMES P * PUD
PRESBYTERIAN MED CTR
PHILADELPHIA PA 19104-2692
215-662-8080
SHOCKMAN, MD, JOEL US
6810 CASTOR AVE
PHILADELPHIA PA 19149-2106
215-745-5581
SHOEMAKER, MD, LARRY D FP
FRANKFORD HOSPITAL
PHILADELPHIA PA 19114-1436
215-612-4110
SHOPE, TIMOTHY R ST
1722 GREEN ST APT C
PHILADELPHIA PA 19130
SHORE, PAUL M ST
325 N 15TH ST #205A
PHILADELPHIA PA 19102
SHORE, MD, SEYMOUR M IM
BENJ FOX PAVILION STE 823B
JENKINTOWN PA 19046
215-886-1311
SHORT, MD, JOHN G IM
220 EVERGREEN ST APT C32
PHILADELPHIA PA 19116
SHOURAIE, MD, ZARRIN PD
9323 LARAMIE RD
PHILADELPHIA PA 19115-2738
215-339-5100
SHRAGER, MD, MORTON W IM
845 HUNT RD
NEWTOWN SQUARE PA 19073-3505
215-829-7004
SHRIVASTAVA, RAJ K ST
3600 CHESTNUT ST BOX 885
PHILADELPHIA PA 19104
SHUBIN, MD, HARRY * IM
1829 PINE ST
PHILADELPHIA PA 19103-6601
215-546-6224
SHULKIN, MD, DAVID J IM
944 MERION SQUARE RD
GLADWYNE PA 19035-1510
215-662-2271
SHULMAN, MD, JOHN F IM
1440 MCKEAN ST
PHILADELPHIA PA 19145-2308
215-334-2237
SHUMAN, MD, CHARLES R DIA
3401 N BROAD ST
PHILADELPHIA PA 19140-5103
215-221-3563
SHUMAN, MD, SANDRA J N
5 W HAMPTON RD
PHILADELPHIA PA 19118-3610
215-222-6583
SHURMAN, BRETT D ST
3614 BARING ST
PHILADELPHIA PA 19104-2333
SHUSTER, MD, EUGENE OBG
2601 HOLME AVE
PHILADELPHIA PA 19152-2007
215-427-9750
SHUSTERMAN, MD, NEIL H NEP
451 BALLYTORE RD
WYNNEWOOD PA 19096-2344
610-832-3074
SHUTACK, DO, JOHN G AN
11 COURTNEY CIR
BRYN MAWR PA 19010-3704
215-448-7960
SHUTACK, JOHN M ST
8201 HENRY AVE APT T-5
PHILADELPHIA PA 19128-2983
SHYAMALAN, MD,
JAYALAKSHMI OBG
132 OLD GULPH RD
WYNNEWOOD PA 19096-1017
SHYAMALAN, MD, NELLIATE C IM
132 OLD GULPH RD
WYNNEWOOD PA 19096-1017
215-425-2525
SIAM, MD, NABIL A P
2991 SCHOOL HOUSE LN APT 032W
PHILADELPHIA PA 19144-5357
SIDDIQI, MD, TARIQ NS
W JERSEY AND PROF PLZ
VOORHEES NJ 08043-4520
609-751-6600
SIEGAL, MD, TODD L R
HAHNEMANN UNIVERSITY HOSP
PHILADELPHIA PA 19102
215-762-4977
SIEGEL, MD, BERNARD OBG
500 OLD YORK RD STE 201
JENKINTOWN PA 19046-2852
215-885-5600

SIEGEL, MD, PAUL D IM
1104 GAINSBORO RD
BALA CYNWYD PA 19004-2013
215-879-0322
SIEGEL, MD, SEYMOUR IM
201 OLD YORK RD STE 205
JENKINTOWN PA 19046-3200
215-885-6767
SIEGFRIED, MD, JAY W PM
296 STONEGATE DR
DEVON PA 19333-1857
610-645-2210
SIEGLER, MD, PETER E A
3837 RED LION RD
PHILADELPHIA PA 19114-1402
215-624-2995
SIEMS, LAURA J ST
3425 TILDEN ST
PHILADELPHIA PA 19129-1434
SIERZENSKI, RONALD J ST
2025 S 3RD ST #3
PHILADELPHIA PA 19148
SIGLER, MD, MILES H NEP
130 LANKENAU MED BLDG WEST
MERION STATION PA 19066-1209
610-649-1175
SIKORSKI, MD, CYNTHIA S ST
1313 KINGSTON WAY #204
CHESAPEAKE VA 23320
SILBER, MD, JEFFREY H PD
CHILDREN'S HOSP
PHILADELPHIA PA 19104
215-590-2540
SILBERMAN, MD, IRA * R
205 N LATCHES LN
MERION STATION PA 19066-1726
SILBERSTEIN, MD, MARSHA M AN
417 SPRUCE ST
PHILADELPHIA PA 19106-3706
SILBERSTEIN, MD, STEPHEN D N
1 PENN BLVD
PHILADELPHIA PA 19144-1407
215-843-5070
SILBERZWEIG, MD, JEFFREY I NEP
4234 BROOKVIEW PL
ELKINS PARK PA 19117-2810
215-662-3601
SILENZIO, MD, VINCENT M B FP
1214 PANAMA ST
PHILADELPHIA PA 19107-5920
215-955-7190
SILER, MD, JANET N AN
2909 HUNTERDON DRIVE
CINNAMINSON NJ 08077
215-762-7962
SILIQUINI, MD, JOHN J OPH
2818 COTTMAN AVE
PHILADELPHIA PA 19149-1419
215-331-4141
SILK, MD, RAYMOND E GS
255 S 17TH ST FL 705
PHILADELPHIA PA 19103-6207
215-985-1810
SILOS, STEPHANIE A ST
1000 WALNUT ST RM 1907
PHILADELPHIA PA 19103
SILVER, MD, BERNICE S GP
127 IRONWOOD RD
LEVITTOWN PA 19057-2751
717-945-4429
SILVER, MD, FRANK OS
2031 MCDANIEL ST STE 210
NORTH LAS VEGAS VA 89030-7165
SILVER, MD, LYNNE J P
6100 CITY AVE APT P115
PHILADELPHIA PA 19131-1250
215-471-2000
SILVER, DO, MARC R R
1612 BRITTANY DR
MAPLE GLEN PA 19002-3151
215-612-4020
SILVERMAN, DO, EDWARD M CDS
649 DODDS LANE
GLADWYNNE PA 19035-1514
215-238-2130
SILVERMAN, MD, WILLIAM S GE
CEDARBROOK HILL APTS B518
WYNCOTE PA 19095-2701
215-879-5888
SILVERSTEIN, MD, GARY S DR
7 WALDEN WAY
CHERRY HILL NJ 08003
215-762-8748
SIMAN, MD, BERNARD AN
507 HOMESTEAD AVE
HADDONFIELD NJ 08033-3023
609-429-2424
SIMERMAN, MD, LEE PAUL R
725 LOMBARD ST
PHILADELPHIA PA 19147-1314
215-893-2027
SIMON, JEFFREY A ST
1100 SPRUCE ST APT 2-D
PHILADELPHIA PA 19107-6008
SIMON, MD, WILLIAM H * ORS
255 S 17TH ST
PHILADELPHIA PA 19103-6231
215-732-1977
SIMPSON, MD, JOSEPH W OM
11 BUGLE LN
BLUE BELL PA 19422-2462

SIMPSON, ZACHARY W ST
630 HAYCLOCK LN
HAVERFORD PA 19041
SINCLAIR, MD, STEPHEN H OPH
216 N BROAD ST 5TH FLR
PHILADELPHIA PA 19102-1101
215-762-7171
SING, DO, RONALD F GS
3400 SPRUCE ST 3 MALONEY
PHILADELPHIA PA 19104
215-662-7320
SINGER, MD, EDWARD S CD
80 TOWNSHIP LINE RD
ELKINS PARK PA 19117-2249
215-339-3030
SINGER, MD, FRED IM
6190 RISING SUN AVE
PHILADELPHIA PA 19111-6011
215-725-8114
SINGER, MD, IRVIN IM
7604 WEST AVE
PHILADELPHIA PA 19117-2511
SINGH, MD, ANJALI H D
2315 KENILWORTH RD
ARDMORE PA 19003-2943
215-662-2737
SINGH, MD, BINOY K IM
8201 HENRY AVE APT N1
PHILADELPHIA PA 19128-2233
SINGH, MD, GURCHARAN PM
6720 RISING SUN AVE
PHILADELPHIA PA 19111-4629
215-342-4777
SINGH, MD, SUNANDA GS
2315 KENILWORTH RD
ARDMORE PA 19003-2943
215-221-7032
SINGLETON, MARLYNN ST
403 HILLSIDE DR
SEWICKLEY PA 15143-9303
SINGSON, MD, PETER P OBG
2201 PENNSYLVANIA AVE
PHILADELPHIA PA 19130
SINHA, MD, LINA M GS
505C S 10TH ST
PHILADELPHIA PA 19147
SINHA, MD, RAJ KAMAL ORS
505 S 10TH ST APT C
PHILADELPHIA PA 19147-1252
215-576-2000
SINK, MD, JAMES D * CDS
51 N 39TH ST
PHILADELPHIA PA 19104-2640
215-662-9167
SINKER, MD, DALE V IM
27 FOXFIELD CT
BROAD AXE PA 19002-5225
215-924-4277
SIRKEN, DO, DAVID H N
10 DARTMOUTH RD
CHERRY HILL NJ 08034-1222
215-842-6000
SIVALINGAM, MD, ARUNAN OPH
160 LANKENAU MEDICAL BLDG E
WYNNEWOOD PA 19096
610-896-0768
SIVALINGAM, MD, JOCELYN F ID
621 LOMBARD ST
PHILADELPHIA PA 19147-1316
215-955-1060
SIVITZ, MD, MARTA E OPH
1726 S BROAD ST STE 101
PHILADELPHIA PA 19145-2321
215-463-3400
SIWEK, YVONNE E ST
6110 ERDRICK ST
PHILADELPHIA PA 19135
SKERRETT, MD, PHILIP V PTH
370 WOODLAND WAY
DUBLIN GA 31040
SKLAROFF, MD, DAVID M RO
639 STETSON RD
ELKINS PARK PA 19117-2524
SKLAROFF, MD, ROBERT B * ON
MEDICAL ARTS BUILDING
ELKINS PARK PA 19117-2253
215-663-8200
SKLAVENITOU, MD, VASSILIKI PD
221 POWELL LN
UPPER DARBY PA 19082-3328
SKOLNICK, MD, BRUCE A OTO
8201 HENRY AVE APT R-20
PHILADELPHIA PA 19128-2253
215-985-8904
SKROMAK, MD, STANLEY J IM
5108 TORRESDALE AVE
PHILADELPHIA PA 19124-2220
215-232-4414
SKVERSKY, MD, NORMAN J PUD
1935 GULF OF MEXICO DR
LONGBOAT KEY FL 34228-3340
SLADKY, MD, JOHN T CHN
CHILDREN'S HOSP
PHILADELPHIA PA 19104-4399
215-590-1719
SLANINA, MD, MICHAEL S PD
1080 OAK RIDGE DR
BLUE BELL PA 19422-3002
215-743-4211
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PHILADELPHIA PA 19102-2913
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SLOCHOWER, MD, DENNIS OPH
1263 CLUB HOUSE RD
GLADWYNE PA 19035-1003
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ALDEN PARK APTS APT 511-C MNR
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506 S 41ST ST APT 4I
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3521 AINSLIE
PHILADELPHIA PA 19129-1629
SNYDER, LORI S ST
1000 WALNUT ST APT 1706-A
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PHILADELPHIA PA 19111-3011
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21 VIOLET LN
LANSDOWNE PA 19050-2320
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STECCO, KATHRYN ST
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9140-A ACADEMY RD
PHILADELPHIA PA 19114-2841
215-331-6050
STEIN, MD, HYMEN D OS
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HUNTINGDON VLY PA 19006
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2068 N OCEAN BLVD
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PHILADELPHIA PA 19114-1397
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PHILADELPHIA PA 19149-1605
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74 AMITY DR
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NARBERTH PA 19072-1619
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PHILADELPHIA PA 19127-1808
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9873A BUSTLETON AVE
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APT N1201 PARK TOWNE PLACE
PHILADELPHIA PA 19130
WEISS, MD, JEFFREY P DR
2020 WALNUT ST APT 26-E
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215-427-7046
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2401 PA AVE APT 18A
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1023 25 CLINTON ST APT 105
PHILADELPHIA PA 19107
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191 PRESIDENTIAL BLVD
BALA CYNWYD PA 19004-1207
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PHILADELPHIA PA 19144-5357
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PHILADELPHIA PA 19141-3040
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PHILADELPHIA PA 19104
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100 W WALNUT LN
PHILADELPHIA PA 19144-2612
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WHYTE, MD, JOHN PM
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359 SPRING VALLEY RD
SPRINGFIELD PA 19064-2231
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212 SHORELINE DR
BERWYN PA 19312-2512
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220 LOCUST ST APT 29F
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GLADWYNE PA 19035-1453
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PHILADELPHIA PA 19106-1941
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PHILADELPHIA PA 19144-5522
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PHILADELPHIA PA 19106
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614 S 27TH ST
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HERSHEY PA 17033

GODSHALL, STEPHEN E ST
2-C DUKE ST
HERSHEY PA 17033-1950

GUILES, STACEY L ST
408 HALLMARK HOUSE
HERSHEY PA 17033

HARKINS, GERALD J ST
2 HICKORY RD
HUMMELSTOWN PA 17036-9206

HARPER, SUSAN J ST
PO BOX 95
HERSHEY PA 17033-0095

HARR, MD, DENISE F ST
1224 PEGGY DR
HUMMELSTOWN PA 17036-9014

HARTZELL, KATHLEEN N ST
455 LOVELL CT
HUMMELSTOWN PA 17055-1512

HAUPT, DANIELE ST
160 UNIVERSITY MANOR E
HERSHEY PA 17033

HELLMANN, JOSEPH R ST
156 UNIVERSITY MNR E
HERSHEY PA 17033

HERNANDEZ, MARISOL ST
23 ROSEDALE
HERSHEY PA 17033-2048

HERTZ, GAIL S ST
RR 9 BOX 172
YORK PA 17402-9333

HESTER, PAUL S ST
4074 ROBINWOOD RD
YORK PA 17402-3211

HOUSER, STEPHEN A ST
505 OAK CIR
WEST CHESTER PA 19380-4523

HUBER, STEPHEN J ST
435 5TH ST
WHITEHALL PA 18052-6440

HUGO, KRISTINE E ST
112 UNIVERSITY MNR
HERSHEY PA 17033-2815

HYDOCK, NICOLE A ST
208 CRESCENT DR
HERSHEY PA 17033-2335

JUSTICE, WILLIAM H ST
117 UNIVERSITY MNR E
HERSHEY PA 17033

KASE, MD, GAIL Y ST
1038 E CHERRY ST
PALMYRA PA 17078-2409

KEGEL, ERICA C ST
16 CHEVY CHASE
HERSHEY PA 17033

KELLER, GREG S ST
187 UNIVERSITY MNR
HERSHEY PA 17033-2824

KELLY, MATTHEW J ST
1817 WEXFORD RD
PALMYRA PA 17078-9242

KIMCHI, ERIC T ST
178 UNIVERSITY MANOR
HERSHEY PA 17033-2822

KLOS, JULIAN W * ST
92 UNIVERSITY MNR E
HERSHEY PA 17033

KOMAN, MD, CHRISTOPHER G ST
70 STONEMARKER DR
WASHINGTON PA 15301-2746

KRAMER, RYAN M ST
UNIVERSITY MANOR E APT 107
HERSHEY PA 17033

KURDZIEL, KAREN A ST
7 WILLIAMSBURG
HERSHEY PA 17033

LAI, JERRY JEOU-JU ST
384 TOWNHOUSE
HERSHEY PA 17033

LEHMAN JR, NORMAN L ST
1115 S OLIVE AVE APT C
ALHAMBRA CA 91803

LENAHAN, SUSAN E ST
1125 PEGGY DR APT #4
HERSHEY PA 17036-9029

LISZKA II, EDWARD G ST
3 WESTMINSTER BLDG
HERSHEY PA 17033

LOWDEN, PATRICK M ST
188 UNIVERSITY MANOR E
HERSHEY PA 15116-1136

LUCAS, MD, TIMOTHY A ST
419 N RAILROAD ST
PALMYRA PA 17078

LUELLEN, JOHN R ST
202 UNIVERSITY MANOR E
HERSHEY PA 17033

MAGUIRE, PATRICK D ST
410 W GOVERNOR RD
HERSHEY PA 17033

MARSHALL, RENEE L ST
15 MCNAUGHTON DR
DUNCANNON PA 17020-9706

MARTINEZ, MANUEL A ST
8 UNIVERSITY MNR
HERSHEY PA 17033-2801

MARTINIE, JOHN B ST
410 W GOVERNOR RD
HERSHEY PA 17033-2215

MC GINN, JOHNATHAN D ST
84 UNIVERSITY MNR E
HERSHEY PA 17033

MC MULLEN, TRACY L ST
288 W MAIN ST
HUMMELSTOWN PA 17036-1428

MC MULLIN, MD, DANA F ST
38 UNIVERSITY MANOR E
HERSHEY PA 17033-2805

MIRANDA, FERNANDO E ST
384 TOWNHOUSE
HERSHEY PA 17033

MISHRA, PRAGYA PM ST
408 HALLMARK S
HERSHEY PA 17033

MISKULIN, JUDIANN ST
18 MONTEREY
HERSHEY PA 17033

MLINAR, LAURA S ST
66 UNIVERSITY MNR E
HERSHEY PA 17033-2829

MODI, JIGNYA J ST
175 UNIVERSITY MANOR E
HERSHEY PA 17033

MOSLEY, MEHRAN ST
178 UNIVERSITY MANOR E
HERSHEY PA 17033-2824

NAYAK, KESHAV R ST
910-G RHUE HAUS LN
HUMMELSTOWN PA 17036

NEVINS, DIANA L ST
540 W CHOCOLATE AVE
HERSHEY PA 17033-1639

OYLER, CYNTHIA E ST
80 UNIVERSITY MANOR E
HERSHEY PA 19446-4823

PENTEL, MD, MARY TRINH ST
139-12 KIRKBRIDE RD
VOORHEES NJ 08043

PIZZINI, MD, MARK-ALAN D ST
STARR RD BOX 384A
AVONDALE PA 19311

RAFFERTY, MAUREEN ST
26-A MAPLE AVE
HERSHEY PA 17033-1455

RAWA, RANDY S ST
1 TIFFANY
HERSHEY PA 17033

REESE, CARL T ST
239 UNIVERSITY MANOR E
HERSHEY PA 17033-2830

REPLOGLE, CORINNE R ST
BRANDYWINE #3
HERSHEY PA 17033

RICE, KEITH S ST
18 UNIVERSITY MANOR E
HERSHEY PA 17033

RICKMAN, CHRISTOPHER E ST
193 UNIVERSITY MANOR E
HERSHEY PA 17033-2825

ROMEO, RYAN C ST
222 TOWNHOUSE
HERSHEY PA 17033-2378

ROTHROCK, CHRISTOPHER R ST
148 UNIVERSITY MANOR EAST
HERSHEY PA 17033-2820

SAVAGE, CARRIE A ST
144 UNIVERSITY MANOR EAST
HERSHEY PA 17033

SCHADDER, CYNTHIA A ST
224 UNIVERSITY MNR
HERSHEY PA 17033-2827

SCHWENTKER, ANDREW E ST
1949 WEXFORD RD
PALMYRA PA 17078-9249

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26 SWARTHMORE
HERSHEY PA 17033

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795 M RHUE HAUS LN
HUMMELSTOWN PA 17036

SIMMONS, MARK L ST
122 FOREST CIR
PALMYRA PA 17078-9745

SIPE, KELLY L ST
427 PENNSYLVANIA AVE
VERONA PA 15147-3824

SLOTTER, TRACY L ST
6 TIFFANY
HERSHEY PA 17033

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232 UNIVERSITY MANOR E
HERSHEY PA 17233

SOBOTA, MD, BRET T ST
125 UNIVERSITY MNR E
HERSHEY PA 17033-2817

SOUNDARARAJAN, VIDYA ST
4 UNIVERSITY MANOR E
HERSHEY PA 17033

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4791 WHITE ROCK CIR APT D
BOULDER CO 80301-3287

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561 W CHOCOLATE AVE 1ST
HERSHEY PA 17033-1640

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18 WESTMONT BLDG
HERSHEY PA 17033

SWIFT, IAN R ST
69 W GRANADA AVE 2ND FLR
HERSHEY PA 17033-1441

TASSONE, ROSALIE F ST
212 UNIVERSITY MANOR E
HERSHEY PA 17033-2826

THOMPSON, HOLLY J ST
836 OAK ST
DENVER PA 17517-1366

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409 HALLMARK ST
HERSHEY PA 17033

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82 UNIVERSITY MANOR E
HERSHEY PA 17033

VIERRA, MARK A ST
1532 MACINTOSH WAY
HUMMELSTOWN PA 17036

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152 UNIVERSITY MNR E
HERSHEY PA 17033

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13 HILLSIDE RD
DAUPHIN PA 17018-9511

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5823 PAVILLION CT
WEXFORD PA 15090

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80 UNIVERSITY MANOR E
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WIEGAND, ROSEMARY A ST
154 UNIVERSITY MNR
HERSHEY PA 17033-2820

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AMSBERRY, MD, JAMES K PHILADELPHIA
AMSHEL, MD, ALBERT L ALLEGHENY
AMSLER JR, MD, FRED R LYCOMING
AMSTER, DO, NORMAN H MONTGOMERY
AMSTERDAM, MD, GERALD H PHILADELPHIA
AMUSO, MD, SAMUEL J DAUPHIN
ANANTHA-RAMAN, MD, AMBALE S ALLEGHENY
ANASTASI, MD, JOHN S BLAIR
ANCHA, MD, PRASAD R NORTHAMPTON
ANDERKO, MD, FRANK T LEHIGH
ANDERSEN, MD, EDWIN MONTGOMERY
ANDERSEN, MD, JOHN M MONTGOMERY
ANDERSEN, MD, ROLF L LANCASTER
ANDERSEN, MD, THOMAS W LANCASTER
ANDERSON, MD, ALICE M PHILADELPHIA
ANDERSON, MD, ARLO C MONTGOMERY
ANDERSON, MD, CAROL E PHILADELPHIA
ANDERSON, MD, CAROLYN H ALLEGHENY
ANDERSON, DEBBIE L STUDENT
ANDERSON, MD, ELIZABETH E LYCOMING
ANDERSON, MD, ELIZABETH J DAUPHIN
ANDERSON, MD, GARY B ALLEGHENY
ANDERSON, DO, GARY L MCKEAN
ANDERSON, MD, GORDON P ERIE
ANDERSON, MD, HERBERT H ALLEGHENY
ANDERSON, MD, JOHN B BERKS
ANDERSON, MD, JOHN R NORTHAMPTON
ANDERSON, KAREN M STUDENT
ANDERSON, MD, KENNETH F CHESTER
ANDERSON, KENNETH W STUDENT
ANDERSON, MD, LEONARD S PHILADELPHIA
ANDERSON, MD, MARIANNE S PHILADELPHIA
ANDERSON, MD, PENNY R STUDENT
ANDERSON, REBECCA STUDENT
ANDERSON, MD, RICHARD E ALLEGHENY
ANDERSON, MD, RONALD B DELAWARE
ANDERSON, MD, STEWART A ALLEGHENY
ANDERSON, MD, THOMAS E FRANKLIN
ANDERSON, TIMOTHY D STUDENT
ANDERSON, MD, VICTOR S WESTMORELAND
ANDERSON, MD, WILLIAM M DAUPHIN
ANDERSON JR, MD, WILLIAM H ERIE
ANDING, MD, ERIC S DAUPHIN
ANDOCHICK, MD, SCOTT E ALLEGHENY
ANDREOZZI, MD, ROBERT J LEBANON
ANDRES, MD, CHRISTOPHER D BRADFORD
ANDREW-JAJA, MD, CAREY D ALLEGHENY
ANDREWS, MD, A THOMAS DAUPHIN
ANDREWS, MD, JOSEPH J LUZERNE
ANDREWS, MD, P JOSEPH DAUPHIN
ANDREWS, MD, PETER J LUZERNE
ANDREWS, SCOTT K STUDENT
ANDREWS, MD, WAVERLY S PHILADELPHIA
ANDREWS III, MD, WILLARD G MONTGOMERY
ANDREWS JR, MD, PETER J LUZERNE
ANDREWS-MURRAY, MD, GAYLE YORK
ANDRIES, MD, RAYMOND C DELAWARE
ANDRIES, MD, RAYMOND M MONTGOMERY
ANDRIOLA, MD, FRANK J DAUPHIN
ANDRIOLE, DO, JAMES M CLINTON
ANDRIOLE, MD, JOSEPH P LACKAWANNA
ANDROKITES, MD, ARTHUR T WESTMORELAND
ANDROSKI, MD, ANNE A PHILADELPHIA
ANDROSKI, MD, JOHN J LACKAWANNA
ANDRUSCAVAGE, DO, LISA A MONTOUR
ANEJA, MD, SURINDER K ALLEGHENY
ANGELICO, MD, RICHARD J LEHIGH
ANGELO, MD, JOHN J YORK
ANGELO, DO, SHARON A PHILADELPHIA
ANGLE, MD, WILLIAM D LYCOMING
ANGLES, MD, CARMEN PHILADELPHIA
ANGSTADT JR, MD, PAUL N MONTGOMERY
ANGULO, MD, ARMAND J FRANKLIN
ANGUS, MD, LESLIE R MONTOUR
ANIGATI, MD, JUAN C MONTGOMERY
ANIS, MD, MUHAMMAD ALLEGHENY
ANISH, ERIC J STUDENT
ANISTRANSKI, MD, JOSEPH A LUZERNE
ANMUTH, DO, CRAIG J PHILADELPHIA
ANNEAR, MD, WILLIAM C GREENE
ANNESLEY JR, MD, WILLIAM H DELAWARE
ANNULIS, MD, THOMAS M YORK
ANO, MD, ANTONIO C PHILADELPHIA
ANOLIK, MD, MITCHELL A PHILADELPHIA
ANOLIK, MD, STEVEN L BEAVER
ANON, MD, JACK B ERIE
ANSON, MD, PETER M LEHIGH
ANSWINE, MD, JOSEPH F DAUPHIN
ANTALIK, MD, PAUL E ALLEGHENY
ANTEMANN, MD, RICHARD W CAMBRIA
ANTENSON, MD, CHARLES M PHILADELPHIA
ANTHONY, MD, JOHN A MONTGOMERY
ANTHOPOULOS, MD, ALEXANDER P DELAWARE
ANTI, MD, ALVISE G ALLEGHENY

ANTICO, MD, DOMINIC A	CAMBRIA
ANTOGNOLI, MD, WILLIAM J	LACKAWANNA
ANTONCIC, MD, RUDY	ALLEGHENY
ANTONELLI, MD, ELENA C	PHILADELPHIA
ANTONELLO JR, MD, ANTHONY	DELAWARE
ANTONETTI, MD, THOMAS B	LYCOMING
ANTONIADES, MD, JOHN	PHILADELPHIA
ANTONUCCI, MD, DONNA L	MONTGOMERY
ANTOON, DO, MICHAEL S	ERIE
ANTOON JR, MD, SALEEM J	WESTMORELAND
ANTOS, MD, THOMAS J	ALLEGHENY
ANTYPAS, MD, PHILIP G	ALLEGHENY
ANZALONE, MD, ANGELO A	LUZERNE
ANZALONE, MD, SALVATORE	BERKS
APATOCZKY, DO, ADRIENNE E	LEHIGH
APEL, MD, AMY L	ALLEGHENY
APONTE, MD, JOSE N	LUZERNE
APPASAMY, MD, RAGUNATH	ALLEGHENY
APPEL, MD, JOHN W	PHILADELPHIA
APPLE, MD, CAROLYN M	YORK
APPLEGATE, DO, DAVID J	BEAVER
APPLEGATE, MD, GERALD B	ALLEGHENY
APPLEGATE, MD, RUSSEL C	DELAWARE
APPLESTEIN, MD, BRUCE	BUCKS
APTON, MD, JEFFREY H	ALLEGHENY
AQUILINA, MD, CHARLES J	LUZERNE
ARANEDA, MD, LUIS O	BLAIR
ARANGIO, MD, GEORGE A	LEHIGH
ARANO, MD, LEONARDO V	MONTGOMERY
ARASTU, MD, MOHAMMAD I	NORTHAMPTON
ARAVABHUMI, MD, SRINIVAS	PHILADELPHIA
ARAVENA, MD, ERNESTO B	ALLEGHENY
ARAYA, MD, FERNANDO	LUZERNE
ARBITMAN, MD, MICHAEL	BLAIR
ARBOGAST JR, MD, JOHN W	UNION
ARBOGAST SR, MD, JOHN W	UNION
ARCH JR, MD, FRANCIS J	ALLEGHENY
ARCIERI II, ROCCO R	STUDENT
ARDITO, MD, JOSEPH M	CHESTER
ARENA, MD, SEBASTIAN	ALLEGHENY
ARENAS, MD, JUAN D	DAUPHIN
ARESERY, MATTHEW J	STUDENT
ARETZ, MD, THOMAS E	CAMBRIA
AREVALO, MD, FERNANDO L	ALLEGHENY
ARGENTINE JR, MD, ROBERT P	ALLEGHENY
ARGER, MD, PETER H	PHILADELPHIA
ARGIRES, MD, JAMES P	LANCASTER
ARILLOTTA, MD, CLYDE	ALLEGHENY
ARISUMI, MD, DAVID N	ALLEGHENY
ARKOOSH, MD, VALERIE A	PHILADELPHIA
ARMANIOUS, MD, ADEL W	WESTMORELAND
ARMAO, MD, JOSEPH J	DELAWARE
ARMENTI, MD, FREDERICK R	PHILADELPHIA
ARMESTO, MD, DAVID M	DAUPHIN
ARMFIELD III, MD, SAMUEL L	ALLEGHENY
ARMITAGE, MD, HARRY V	DELAWARE
ARMONIO JR, MD, JOSE G	DELAWARE
ARMOUR, DO, THOMAS F	MERCER
ARMOUR, MD, WILLIAM S	PHILADELPHIA
ARMSTRONG, MD, DELILAH	DAUPHIN
ARMSTRONG, MD, MARK E	CLINTON
ARMSTRONG, MD, THOMAS A	MONTGOMERY
ARNAO, MD, JAMES	PHILADELPHIA
ARNDT, MD, JAMES L	BERKS
ARNER, MD, RAYMOND H	NORTHAMPTON
ARNHEIM, MD, FALK K	ALLEGHENY
ARNO, MD, J THOMAS	CRAWFORD
ARNOLD, BLAKE WINN	STUDENT
ARNOLD, MD, JOHN J	CLEARFIELD
ARNOLD, MD, LAURA S	ALLEGHENY
ARNOLD, MD, RICHARD E	FRANKLIN
ARNOLD, SARAH J	STUDENT
ARNOLD, DO, WAYNE V	MONTGOMERY
ARNOUK, MD, NABIL T	JEFFERSON
ARONICA, MD, MICHAEL J	LACKAWANNA
ARONOFF, MD, ROBERT D	DAUPHIN
ARONSON, MD, JEROLD M	PHILADELPHIA
ARONSON, MD, MORTON L	ALLEGHENY
ARONSTAM, MD, ROBERT H	BRADFORD
ARORA, MD, ANJALI	PHILADELPHIA
ARORA, MD, MANJU	DELAWARE
ARORA, MD, RAMESH	CUMBERLAND
ARORA, MD, SAT P	DELAWARE
ARORA, MD, SUBHASH C	LACKAWANNA
AROUH, MD, ALBERT	DELAWARE
ARROW, DO, BEREL B	LANCASTER
ARSHT, DO, DAVID B	DELAWARE
ARSHT, MD, EDWIN D	DELAWARE
ARSUAGA, MD, JORGE E	PHILADELPHIA
ARTHUR, MD, BRIAN W	DAUPHIN
ARTHUR, MD, JAMES B	MCKEAN
ARTHUR, MD, KENNETH R	LANCASTER
ARTIS, MD, CATHY J	ALLEGHENY
ARTUSO, MD, FRANK B	ALLEGHENY
ARTUSO, MD, JAMES D	LANCASTER
ARUMUGARAJAH, MD, KANAGASABAPATHY	ADAMS
ASAM, MD, BRUCE A	PHILADELPHIA
ASATO, AMY J	STUDENT
ASBELL, MD, SUCHA O	PHILADELPHIA
ASCANIO JR, MD, GUIDO J	BERKS
ASEEM, MD, WALI M	JEFFERSON
ASH, MD, S RUSSELL	MONTGOMERY
ASHBAUGH, MD, WILLIAM H	BUTLER
ASHBY, MD, BONNIE L	DELAWARE
ASHBY, MD, JOHN D	FRANKLIN
ASHBY, THOMAS C	STUDENT
ASHMAN, MD, GEORGE S	CAMBRIA
ASHWORTH, MD, HALBERT E	BERKS
ASKAR, MD, F	PHILADELPHIA
ASKIN, MD, STANLEY R	PHILADELPHIA
ASKINAS, MD, ALAN M	CHESTER
ASLAM, MD, AZAR	CRAWFORD
ASLAM, MD, MASOOD	PHILADELPHIA
ASLAM, MD, MOHAMMAD	SCHUYLKILL
ASLAM, MD, MOHAMMED	SOMERSET
ASMAN, MD, BARRY J	ALLEGHENY
ASMAR, MD, HODA A	DAUPHIN
ASO, MD, ORLANDO A	CARBON
ASPILI, MD, CONCEPCION S	PHILADELPHIA
ASPINALL, MD, ALAN R	WESTMORELAND
ASSANASEN, MD, BENJA V	WESTMORELAND
ASSANASEN, MD, CHARIN	WESTMORELAND
ASSARSSON, MD, ERIK D	MONTGOMERY
ASTA, MD, LISA M	PHILADELPHIA
ASTARITA, MD, SALVATORE J	LANCASTER
ASTHANA, MD, SHOBHA	ALLEGHENY
ASTRA, LOUIS I	STUDENT
ASTROFF, MD, MATTHEW R	CHESTER
ATHANI, MD, VIJAY S	ALLEGHENY
ATHREYA, MD, BALU H	PHILADELPHIA
ATKIN, MD, DAVID H	ALLEGHENY
ATKINS, MD, JOHN L	YORK
ATKINS, MD, ROBERT F	MONTGOMERY
ATKINS, MD, ROBERT M	YORK
ATKINS, MD, WILLIAM R	CHESTER
ATKINS JR, MD, JOSEPH P	PHILADELPHIA
ATKINS JR, MD, WILLIAM R	PHILADELPHIA
ATKINSON, MD, BARBARA F	PHILADELPHIA
ATKINSON, MD, DONALD P	ALLEGHENY
ATKINSON, MD, NOLAN N	MONTGOMERY
ATKINSON, MD, PAMELA A	DELAWARE
ATLAS, MD, ROBERT O	LEHIGH
ATTOLINO, DO, RAYMOND B	PHILADELPHIA
ATWELL, MD, MARGARET S	BERKS
ATWELL, MD, ROBERT B	ALLEGHENY
ATWELL SR, DO, GRANT E	SOMERSET
AUCH, MD, ELLA M	NORTHAMPTON
AUCHENBACH, MD, RALPH C	ALLEGHENY
AUDAY, MD, JOSE H	PHILADELPHIA
AUERBACH, DO, BENJAMIN H	CHESTER
AUERBACH, MD, HERMAN L	LUZERNE
AUERBACH, DO, JEFFREY C	WAYNE/PIKE
AUERBACH, MD, MARK H	NORTHAMPTON
AUERBACH, MD, ROBERT L	PHILADELPHIA
AUERBACH, DO, ROBERT S	PHILADELPHIA
AUGELLI-HODOR, DO, LINDA P	NORTHAMPTON
AUGSBURGER, MD, JAMES J	PHILADELPHIA
AUL, JEROME J	STUDENT
AULT, MD, GLENN T	PHILADELPHIA
AURE, MD, HORACIO S	ALLEGHENY
AURE, MD, ISABEL R	ALLEGHENY
AURITT, MD, WILLIAM A	MONTGOMERY
AUSTIN, CHRISTINE E	STUDENT
AUSTIN, MD, EDWARD M	ALLEGHENY
AUSTIN, MD, GREGORY E A	JEFFERSON
AUSTIN JR, MD, CHARLES B	DAUPHIN
AUSTRIAN, MD, ROBERT C	PHILADELPHIA
AUTERI, MD, ANTHONY G	LEHIGH
AVANCENA, MD, EDGARDO P	MONTGOMERY
AVART, DO, HERBERT	DELAWARE
AVART, DO, MARK D	MONTGOMERY
AVEDISSIAN, MD, MICHAEL G	BERKS
AVELLA, MD, BERARD N	BERKS
AVELLINO, MD, JOSEPH D	PHILADELPHIA
AVENIA, MD, RONALD J	COLUMBIA
AVERBACH, DAVID H	STUDENT
AVERION-MAHLOCH, TIMOTHY J	STUDENT
AVERSA, THADDEUS M	STUDENT
AVERSA JR, MD, ZEFFERINO A	PHILADELPHIA
AVILA, MD, PEDRO C	PHILADELPHIA
AVINA, MD, LINDLEY G	PHILADELPHIA
AVNER, MD, DAVID L	GREENE
AWAN, MD, IHSAN H	ALLEGHENY
AWAN, MD, RASHID A	CAMBRIA
AWTREY, CHRISTOPHER S	STUDENT
AXELROD, MD, BUDD B	PHILADELPHIA
AXELROD, MD, JANICE H	ALLEGHENY
AXELROD, MD, LAWRENCE S	MONTGOMERY
AXELROD, DO, NORMAN M	LANCASTER
AXELROD, MD, RANDI A	PHILADELPHIA
AXELSON, MD, ALAN A	ALLEGHENY
AYASSO, MD, M SAMIR	ALLEGHENY
AYDIN, MD, ABED A	JEFFERSON
AYERLE, MD, ROBERT S	PHILADELPHIA
AYERS, MD, LLOYD R	BLAIR
AYERS JR, MD, WILLIAM H	DELAWARE
AYLWARD, MD, JOHN J	CHESTER
AYRES, MD, WILLIAM W	FAYETTE
AZAB, MD, AMANY K	CAMBRIA
AZAR, MD, ALBERT A	YORK
AZAR, MD, MICHAEL J	ALLEGHENY
AZAR, MD, REZA R	BUCKS
AZCONA, MD, OSCAR C	WASHINGTON
AZER, MD, MAGDI S	CAMBRIA
AZIMI, SOHEIL	STUDENT
AZIZ, MD, ABDULRAB	ALLEGHENY
AZIZI, MD, FRAIDON F	ALLEGHENY
AZIZKHAN, MD, REZA G	DAUPHIN
AZURIN, MD, ARTURO C	ALLEGHENY

B

BAASE, MD, CAROL A	LEBANON
BABIAK, MD, OLESH	DELAWARE
BABINECZ, MD, JOHN M	CHESTER
BABRA, MD, SUDHA T	BEDFORD
BABUSCHAK, JEFFREY M	STUDENT
BACA, MD, HEIDI J	PHILADELPHIA
BACAK, MD, JOSEPH F	NORTHAMPTON
BACASTOW, MD, MERLE S	YORK
BACCASH, MD, PATRICIA D	PHILADELPHIA
BACESKI, MD, DEBORAH A	SOMERSET
BACHARACH, MD, BENJAMIN	PHILADELPHIA
BACHARACH, MD, MATTHEW D	LANCASTER
BACHMAN, MD, WILLIAM H	LANCASTER
BACKENSTOSE, MD, DANIEL L	DAUPHIN
BACKES, MD, CELSO L	POTTER
BACON, MD, RICHARD W	LANCASTER
BADAMO, MD, FRANCIS P	JEFFERSON
BADARACCO, MD, MARIE R	COLUMBIA
BADAWI, MD, RADWAN A	LACKAWANNA
BADAYOS, MD, ALICIA P	BUCKS
BADER, MD, KAREN M	MONTGOMERY
BADHEY, MD, VASANTHA	PHILADELPHIA
BADIALI, MD, S CHARLES	WASHINGTON
BADOLATO, MD, DAVID J	MONTGOMERY
BADOSA, MD, FRANCISCO	PHILADELPHIA
BADWAY, MD, DAVID M	ALLEGHENY
BAENS, MD, MARIA P C	ALLEGHENY
BAER, MD, GERALD R	LANCASTER
BAER, MD, HARRY M	PHILADELPHIA
BAER, JAMES R	STUDENT
BAER, MD, MICHAEL T	DAUPHIN
BAER, MONIQUE M	STUDENT
BAER, MD, SAMUEL	PHILADELPHIA
BAERTL, MD, JUAN M	YORK
BAFFONI JR, MD, ALBERT D	ALLEGHENY
BAGDORF, MD, ROBERT	INDIANA
BAGHAI-NAIINI, MD, PARVIZ	ALLEGHENY
BAGHERI, MD, SAEED A H	LEBANON
BAGLEY, MD, DEMETRIUS H	PHILADELPHIA
BAHADARI, ALI	STUDENT
BAHL, MD, MOHINDER M	ALLEGHENY
BAHL, MD, VIJAY K	ALLEGHENY
BAHLER, MD, EILEEN	WESTMORELAND
BAIKADI, MD, MADHAVA	LACKAWANNA
BAILER, DO, ALAN S	MONTGOMERY
BAILES JR, MD, JULIAN E	ALLEGHENY
BAILEY, MD, DOMINIQUE R	NORTHAMPTON
BAILEY, MD, LAUREL P	CUMBERLAND
BAILEY, MD, STEPHEN R	ALLEGHENY
BAILEY, MD, THOMAS M	NORTHAMPTON
BAILEY, MD, WILLIAM R	ALLEGHENY
BAILEY III, DO, JOHN H	CRAWFORD
BAILEY JR, MD, JOHN H	CRAWFORD
BAILEY JR, LEONARD C	STUDENT
BAILEY JR, MD, ROBERT S	MONTGOMERY
BAILEY JR, DO, WILLIAM H	ALLEGHENY
BAILY, MD, ROBERT G	DAUPHIN
BAINBRIDGE, MD, WILLIAM J	CHESTER
BAIO, MD, MICHAEL V	DELAWARE
BAIR, MD, JEFFREY F	MONROE
BAIR, MD, ROBERT C	TIOGA
BAIR, MD, VICTOR W	WASHINGTON
BAIR, MD, WILLIAM L	ALLEGHENY
BAIRD, MD, EDWARD F	LANCASTER
BAIRD, MD, JAMES W	ALLEGHENY
BAIRD, JANET L	STUDENT
BAIRD, KRISTIN	STUDENT
BAIRD, MD, ROBERT M	MONROE
BAJAJ, MD, RAJESH	ADAMS
BAJAJ, MD, RAJIV K	LACKAWANNA
BAJWA, MD, SURINDER S	WESTMORELAND
BAKER, MD, CAROL C	ALLEGHENY
BAKER, MD, DAVID G	LANCASTER
BAKER, MD, DONALD J	PHILADELPHIA
BAKER, MD, GRAEME C	ERIE
BAKER, MD, JEFFREY H	CENTRE
BAKER, MD, KAREN S	ALLEGHENY
BAKER, MD, LESTER	PHILADELPHIA
BAKER, MD, MARK D	PHILADELPHIA
BAKER, MD, MARK S	CENTRE
BAKER, MD, MARVIN P	BUTLER
BAKER, MD, R J	BEAVER
BAKER, RANDOLPH M	STUDENT
BAKER, MD, ROBERT H	MERCER
BAKER, MD, ROBERT L	ALLEGHENY
BAKER, MD, ROY F	CENTRE
BAKER, DO, TERENCE R	BERKS
BAKER, MD, THOMAS E	LUZERNE
BAKER, MD, WALTER J	ALLEGHENY
BAKER II, DO, ROBERT L	ALLEGHENY
BAKER JR, MD, GEORGE W	FRANKLIN
BAKEWELL, MD, FRANK S	WASHINGTON
BAKSHI, MD, KALIND R	PHILADELPHIA
BAKSHI, MD, KINNARI K	BUCKS
BAKTH, MD, SHAMSHER	ALLEGHENY
BALACKO, MD, JOHN A	ALLEGHENY
BALARAMAN, MD, GOVINDACHETTY	FRANKLIN
BALASH, MD, WILLIAM R	ARMSTRONG
BALASUBRAMANIAM, MD, MANI	FAYETTE
BALASUBRAMANIAN, MD, EASWARAN	PHILADELPHIA
BALCHANDANI, MD, RAJKUMARI B	PHILADELPHIA
BALCITA, MD, ARTHUR L	WESTMORELAND
BALDASSANO, MD, ROBERT N	MONTOUR
BALDECK, MD, ANDREA M	PHILADELPHIA
BALDER JR, MD, DONALD A	ALLEGHENY
BALDERACH, MD, RONALD R	LAWRENCE
BALDERSTON, MD, RICHARD A	PHILADELPHIA
BALDI, DO, CHRISTOPHER L	MONTOUR
BALDIA, MD, LIVEO B	COLUMBIA
BALDUCCI, MD, JAMES	LEHIGH
BALDWIN, MD, HAROLD S	PHILADELPHIA
BALDWIN, MD, ROBERT C	DAUPHIN
BALDWIN, MD, THOMAS M	BEAVER
BALDYS, MD, JAMES S	LYCOMING
BALEANU-MALLOZZI, MD, RALUCA I	LANCASTER
BALI, MD, AJAY K	LUZERNE
BALIN, MD, ARTHUR K	DELAWARE
BALIN, MD, BENJAMIN R	DELAWARE
BALING, MD, LARRY E	MERCER
BALINT, MD, BART W	ERIE
BALISTOCKY, MD, MARVIN H	MONTGOMERY
BALK, MD, JUDITH L	ALLEGHENY
BALK, MD, PHILLIP	ALLEGHENY
BALKIAN, GARO K	STUDENT
BALL, MD, ANDREW G	PHILADELPHIA
BALL, DO, DAVID J	COLUMBIA
BALLANTYNE, MD, JAMES V	ALLEGHENY
BALLARD, MD, IAN M	MONTGOMERY
BALLARD, MD, ROBERTA A	PHILADELPHIA
BALLEK, MD, RONALD E	PHILADELPHIA
BALLENTINE, MD, GEORGE N	LYCOMING
BALLS, MD, KENT F	MONTGOMERY
BALMASEDA, MD, MARIO T	ERIE
BALMASEDA, MD, OFELIA B	PHILADELPHIA
BALMER, DO, JOHN E	CRAWFORD
BALOCH, MD, ZUBAIR W	PHILADELPHIA
BALOG, MD, BALINT	DAUPHIN
BALOGH JR, MD, ROBERT J	LEBANON
BALOURIS, MD, CHRIST A	ALLEGHENY
BALSAMO, MD, ANTHONY J	PHILADELPHIA
BALSBAUGH, MD, GEORGE T	DAUPHIN
BALSHI, MD, JAMES D	NORTHAMPTON
BALSHI, MD, STEPHEN F	NORTHAMPTON
BALTAROWICH, MD, OKSANA H	PHILADELPHIA
BALTZ, MD, RICHARD D	DAUPHIN
BALTZELL, MD, WILLIAM H	PHILADELPHIA
BAMBERGER, MD, GRANT W	CHESTER
BAMBERGER, MD, JOHN A	LEBANON
BAMONT, MD, ANTHONY J	PHILADELPHIA
BAMONTE, MD, EDWARD L	ALLEGHENY
BANCROFT, MD, EDITH D	MONTGOMERY
BANCROFT, MD, URSULA F	PHILADELPHIA
BANDALA, MD, LEONARD C	NORTHAMPTON
BANDARANAYAKE, MD, NISANTHA M	WESTMORELAND
BANDARANAYAKE, MD, PICHING	ALLEGHENY
BANDINI JR, MD, PAUL J	PHILADELPHIA
BANE, MD, DENIS M	SCHUYLKILL
BANERJI, MD, BASHAB	DAUPHIN
BANEY IV, PHILIP J	STUDENT
BANEY JR, MD, CHARLES M	BERKS
BANICK, MD, PAUL D	DELAWARE
BANIEWICZ JR, MD, FRANK J	MERCER
BANK, MD, R STANLEY	DAUPHIN
BANKA, MD, REENA S	PHILADELPHIA
BANKA, MD, VIDYA S	PHILADELPHIA
BANKACI, MD, MURAT	WESTMORELAND
BANMILLER, MD, JAMES D	MONTGOMERY
BANNER, MD, RICHARD N	MONTGOMERY
BANNER, MD, RONALD S	PHILADELPHIA
BANNING, DO, RICHARD J	SCHUYLKILL
BANNISTER JR, MD, WILLIAM B	LAWRENCE
BANNON, MD, CHARLES J	LACKAWANNA
BANNON, MD, JOSEPH P	PHILADELPHIA
BANOGON, MD, MARIETTA A	DAUPHIN
BANQUERIGO, MD, ELDINE A	BERKS
BANSAL, MD, SURENDRA K	ALLEGHENY
BANSAL, MD, VIJAYA	ALLEGHENY
BANSBACH, MD, JEAN M	PHILADELPHIA
BANSBACH, MD, WILLIAM A	PHILADELPHIA
BANSIDHAR, MD, BHADRASINE	BEAVER
BANTLY, MD, VICTOR S	CAMBRIA
BANZHOFF, MD, GORDON K	DAUPHIN
BAQUERO-BUENO, MD, MARIO R	WASHINGTON
BAR, MD, ALLEN H	PHILADELPHIA
BARAD, MD, ROXANA F	ALLEGHENY
BARAFF, MD, ROBERT	ALLEGHENY
BARAKAT, MD, ADEL R	LACKAWANNA
BARAN, MD, ERNEST M	MONTGOMERY
BARAN, MD, JAMES J	ALLEGHENY
BARANSKI, MD, EDWARD J	ADAMS
BARATZ, MD, BURTON H	PHILADELPHIA
BARATZ, MD, MARK E	ALLEGHENY
BARBA III, MD, WILLIAM P	BUCKS
BARBARISI, MD, MARCHELLO J	PHILADELPHIA
BARBEE, GLEN J	STUDENT
BARBER, MD, JAMES J	ALLEGHENY
BARBER, MD, JOHN C	ALLEGHENY
BARBER, MD, JOHN V	WESTMORELAND
BARBER, MD, JOSEPH C	ERIE
BARBER, MD, LEE A	PHILADELPHIA
BARBER, MD, MARGARET	PHILADELPHIA
BARBERA, MD, CHARLES F	PHILADELPHIA
BARBOT, MD, DONNA J	PHILADELPHIA
BARCH, MD, FRANK J	CHESTER
BARCKHAUSEN, MD, RALF R	PHILADELPHIA
BARCLAY, MD, CLAYTON C	SCHUYLKILL
BARD, MD, JOSEPH L	MONTGOMERY
BARDELL, MD, CRAIG R	SCHUYLKILL
BARDZIL, MD, JOSEPH W	WASHINGTON
BARENBERG, MD, PAUL A	CHESTER
BARG, MD, RONALD B	MONTGOMERY
BARI, MD, MERLE M	MONTGOMERY
BARILLA, MD, DONALD E	LEHIGH
BARKE, MD, JAMES N	POTTER
BARKER, MD, CLYDE F	PHILADELPHIA
BARKER, MD, RICHARD G	PHILADELPHIA
BARLEY, MD, SAMUEL B	JEFFERSON
BARLOW, DO, ALFRED M	YORK
BARLOW JR, MD, ROBERT A	PHILADELPHIA

BARMADA, MD, BICHER	ALLEGHENY
BARNA, MD, NICHOLAS J	MONTOUR
BARNABY JR, MD, ARTHUR J	PHILADELPHIA
BARNES, MD, ANNE U	PHILADELPHIA
BARNES, MD, BARBARA E	ERIE
BARNES, MD, BEN C	LEHIGH
BARNES, MD, DENICE M	BUCKS
BARNES, MD, FREDERICK J	MONROE
BARNES, MD, MARGARET M	PHILADELPHIA
BARNES, MD, W STEPHEN	CENTRE
BARNES, MD, WILLIAM J	ALLEGHENY
BARNES, MD, WILLIAM T	CENTRE
BARNES, MD, WILLIS C	LACKAWANNA
BARNETT, MD, ALAN J	ALLEGHENY
BARNETT, MD, CHARLES F	PHILADELPHIA
BARNETT, MD, JORDAN B	PHILADELPHIA
BARNHOUSE, MD, DAVID H	ALLEGHENY
BARNICLE, MD, MARYANNE	INDIANA
BARNOSKI, MD, JOHN F	DAUPHIN
BARNWELL, MD, ANNE-BATTISTE	ERIE
BAROLAT-ROMANA, MD, GIANCARLO	PHILADELPHIA
BARON, DO, DAVID A	MONTGOMERY
BARON, MD, JOHN	ALLEGHENY
BARON, MD, RAYMOND C	PHILADELPHIA
BARON, MD, RICHARD J	PHILADELPHIA
BARON, MD, SCOTT L	ALLEGHENY
BARON JR, MD, ANDREW J	LACKAWANNA
BARONE, MD, ANTHONY	LEHIGH
BARONE, DO, PAUL F	CHESTER
BARONE, MD, SAMUEL F	ALLEGHENY
BARR, MD, GARY A	ALLEGHENY
BARR, MD, GAVIN C	NORTHAMPTON
BARR, MD, HARRY J	MONTGOMERY
BARR, DO, LAWRENCE I	PHILADELPHIA
BARR, MD, LYNN D	STUDENT
BARR, MD, RICHARD G	DELAWARE
BARR, MD, V WARD	LANCASTER
BARR JR, MD, JAMES H	ALLEGHENY
BARRAS, MD, DAVID I	LUZERNE
BARRASSE, MD, LINDA D	LACKAWANNA
BARREN, DO, ERIC P	LACKAWANNA
BARRER, MD, MITCHELL J	BUCKS
BARRER, MD, STEVEN J	MONTGOMERY
BARRESI, DO, MARY L	ALLEGHENY
BARRETT, MD, GEORGE S	NORTHAMPTON
BARRETT, MD, JAMES P	BERKS
BARRETT, MD, JOHN L	ALLEGHENY
BARRETT, MD, MICHAEL J	PHILADELPHIA
BARRETT, MD, MICHAEL J	LACKAWANNA
BARRETT, MD, PETER W	BRADFORD
BARRETT, RONALD T	STUDENT
BARRETT, MD, STEPHEN J	LEHIGH
BARRETT, MD, WILLIAM A	ALLEGHENY
BARRETT, DO, WILLIAM M I	MONTGOMERY
BARRETTE, MD, ROGER R	WASHINGTON
BARRINGER, MD, LYDIA R	PHILADELPHIA
BARRIOS, MD, MARIO F	BERKS
BARRIS, MD, BRUCE J	BUCKS
BARRISH, WILLIAM J	STUDENT
BARRIST, MD, ELLIS M	PHILADELPHIA
BARRY, MD, WILLIAM E	PHILADELPHIA
BARRY, MD, WILLIAM J	CHESTER
BARSKY, DO, HOWARD EDWIN	PHILADELPHIA
BARSOUM, MD, ADIB H	WESTMORELAND
BARSZCZOWSKI JR, MD, PETER J	LAWRENCE
BARTELT, DO, MATTHEW S	NORTHAMPTON
BARTGES, MD, JOHN D	LANCASTER
BARTH, MD, JULIE C	DAUPHIN
BARTH, MD, LINDA J	PHILADELPHIA
BARTHO, MD, BLAINE F	PERRY
BARTKOWSKI, MD, RICHARD R	DELAWARE
BARTLE JR, MD, HARVEY	MONTGOMERY
BARTLETT JR, MD, FREDERICK H	MONTGOMERY
BARTLOW, MD, WILLIAM P	LYCOMING
BARTMAN, THOMAS	STUDENT
BARTNIK, MD, JOHN K	ALLEGHENY
BARTOLANZO, MD, ROBERT A	BUCKS
BARTOLET, MD, TERRY L	NORTHAMPTON
BARTOLOZZI, MD, MARIA A	PHILADELPHIA
BARTON, MD, F JANE	DAUPHIN
BARTON, MD, JAMES C	FRANKLIN
BARTON, MD, JOHN O	DAUPHIN
BARTON, MICHAEL E	STUDENT
BARTON, MD, ROBERT L	LEBANON
BARTONE, MD, FRANCIS F	MONTOUR
BARTOS, MD, JOSEPH E	NORTHAMPTON
BARTOS, MD, SYLVIA A	WASHINGTON
BARTOSIK, MD, DELPHINE B	PHILADELPHIA
BARTUSKA, MD, DORIS G	PHILADELPHIA
BARUA, MD, SUBRATA P	WESTMORELAND
BARZEL, MD, EYAL	PHILADELPHIA
BARZYK, MD, PETER P	ERIE
BASALA, DO, PHILIP A	SOMERSET
BASARAB, MD, ROBERT M	LANCASTER
BASCOM, MD, KAREN D	DAUPHIN
BASELLI, EDGAR C	STUDENT
BASEMAN, MD, ALAN S	BUCKS
BASEMAN, MD, DEBRA M	PHILADELPHIA
BASH, MD, EVAN K	DELAWARE
BASHEDA, DO, STEPHEN G	ALLEGHENY
BASHLINE, DO, BRUCE S	DAUPHIN
BASHLINE, MD, DON L	MERCER
BASHORE JR, MD, ROBERT M	LANCASTER
BASILE, MD, JOSEPH	BLAIR
BASKA, MD, JOHN K	BEAVER
BASOM, MD, DONALD E	MIFFLIN/JUNIATA
BASSALY, MD, RIFAAT R	LAWRENCE
BASSETT, MD, DEBORAH W	PHILADELPHIA
BASSETT, MD, JAMES G	PHILADELPHIA
BASSILIOS, MD, FOUAD A	ALLEGHENY
BAST, MD, WILLIAM R	ADAMS
BASTIAN, MD, GRACE A	PHILADELPHIA
BASTIAN, MD, JAMES R	LYCOMING
BASTIN, MD, KENNETH T	LACKAWANNA
BASTING, MD, GREGORY G	LACKAWANNA
BATCHELDER, MD, BARRON M	BERKS
BATCHELET, DO, RICHARD B	DELAWARE
BATCHELOR, MD, ALLISON J	BEAVER
BATHRICK, MD, CHARLES E	ERIE
BATIPPS JR, MD, PERCY O	DELAWARE
BATLLE, MD, FRANCISCO J	PHILADELPHIA
BATOFF, MD, MILTON A	PHILADELPHIA
BATOK, MD, GARY R	LUZERNE
BATORY, MD, KATHERINE H	CENTRE
BATRA, MD, PREET M	PHILADELPHIA
BATSHAW, MD, MARK L	PHILADELPHIA
BATTAFARANO, MD, LEONARD A	PHILADELPHIA
BATTAFARANO, MD, NICHOLAS C	CHESTER
BATTAGLIA, DO, DANIEL R	DAUPHIN
BATTAGLIA, MD, PAUL G	SOMERSET
BATTERTON, MD, THOMAS D	PHILADELPHIA
BATTISTA, MD, FRANK J	DAUPHIN
BATTISTELLA, DO, GENE M	ALLEGHENY
BATTLE, MD, WILLIAM M	PHILADELPHIA
BATZEL, MD, EDWARD L	LACKAWANNA
BATZER, MD, FRANCES R	PHILADELPHIA
BAUER, MD, FRANK L	ALLEGHENY
BAUER, MD, JAMES E	INDIANA
BAUER, MD, JAMES E	ARMSTRONG
BAUER, KRISTEN M	STUDENT
BAUER, MD, ROBERT L	LEBANON
BAUER, MD, THOMAS L	YORK
BAUERLE, MD, WAYNE B	PHILADELPHIA
BAUERS, MD, JOHN C	ERIE
BAUERSFELD, MD, S RICHARD	ALLEGHENY
BAUM, MD, ALICIA	WESTMORELAND
BAUM, MD, EDGAR S	LEHIGH
BAUM, MD, JEFFREY A	ALLEGHENY
BAUM, JONATHAN D	STUDENT
BAUM, MD, NEIL B	WESTMORELAND
BAUM, MD, SHELDON F	DELAWARE
BAUMAN, MD, DOROTHY H	ALLEGHENY
BAUMAN, DO, JOHN M	ERIE
BAUMANN, MD, MICHAEL R	ALLEGHENY
BAUMBACH, JENNIFER L	STUDENT
BAUMGARDNER, MD, JAMES E	PHILADELPHIA
BAUMGART, MD, JUDY R	CUMBERLAND
BAUMGARTEL, MD, IRA E	ALLEGHENY
BAUMWELL, MD, IVAN A	ALLEGHENY
BAURER, MD, FREDERIC M	PHILADELPHIA
BAUSCH, MD, ANDREW N	LEHIGH
BAUSCH, MD, RICHARD D	LEHIGH
BAUSCH JR, MD, FREDERICK R	LEHIGH
BAUTISTA, MD, PRIMO V	WESTMORELAND
BAVARIA, MD, JOSEPH E	PHILADELPHIA
BAVER, MD, GEORGE A	MONTGOMERY
BAXLEY, MD, MICHAEL N	MERCER
BAXTER JR, MD, DONALD L	ERIE
BAYANI JR, MD, ELADIO Y	WESTMORELAND
BAYER, DO, JAY D	FRANKLIN
BAYER, MD, JOSEPH F	WASHINGTON
BAYRI, MD, MEHMET F	LEHIGH
BAYUK, MD, JOHN D	BEAVER
BAYUK, MD, JULIAN M	MONTGOMERY
BAZARGANI, MD, TAWOOS	MONTGOMERY
BAZARNIC, MD, MARGARET L	BERKS
BAZEWICZ, MD, ROBERT A	LEBANON
BAZMI, MD, HASSAN	ALLEGHENY
BAZMI, MD, NEPTUNE K	ALLEGHENY
BAZRON, MD, HERBERT	ALLEGHENY
BAZYLAK, MD, ROBERT A	CRAWFORD
BAZZOUI, MD, WIDAD	MCKEAN
BEACHER JR, MD, GEORGE W	LANCASTER
BEACHLER, MD, JOHN S	ALLEGHENY
BEACHLEY, MD, MICHAEL C	ALLEGHENY
BEACHY, MD, IVAN E	CUMBERLAND
BEACHY, MD, STANLEY C	CUMBERLAND
BEALE, MD, BENJAMIN R	DAUPHIN
BEALER, MD, JOHN D	NORTHAMPTON
BEALL, MD, SANDRA C	LYCOMING
BEAN, MD, CARL B	BUTLER
BEANE, MD, JEFFREY C	DAUPHIN
BEARD, DO, GREGORY K	ERIE
BEARDWOOD, MD, DONALD M	MONTGOMERY
BEASTON-WIMMER, PATRICIA R	STUDENT
BEATON, DO, DAVID L	ERIE
BEAUCHAMP, DO, BRUCE W	ALLEGHENY
BEAUCHAMP JR, MD, EUGENE W	PHILADELPHIA
BEAUDREAU, MD, DAVID G	ALLEGHENY
BEAUSANG, MD, THOMAS	SCHUYLKILL
BEAVEN, MD, BARRY J	YORK
BEAVER, MD, WARREN J	ERIE
BEBB, MD, DONALD R	MONTGOMERY
BECERRA-CABAL, MD, LUIS I	MONTGOMERY
BECICH, MD, MICHAEL J	ALLEGHENY
BECK, MD, AARON T	PHILADELPHIA
BECK, MD, ALLAN G	PHILADELPHIA
BECK, MD, CHRISTINE H	NORTHAMPTON
BECK, MD, GERALD	ERIE
BECK, MD, GUNHILDE M	DAUPHIN
BECK, MD, JAN	BRADFORD
BECK, MD, JEFFREY A	DELAWARE
BECK, DO, JONATHAN E	MONTGOMERY
BECK, MD, LAURENCE H	MONTOUR
BECK, MD, ROBERT H	HUNTINGDON
BECK, MD, SYLVIA R	PHILADELPHIA
BECK, MD, WILLIAM C	BRADFORD
BECKER, MD, BRUCE	COLUMBIA
BECKER, MD, CARL E	STUDENT
BECKER, MD, IRWIN	PHILADELPHIA
BECKER, MD, JENNIFER L	PHILADELPHIA
BECKER, DO, JOHN C	LYCOMING
BECKER, MD, JOSEPH M	PHILADELPHIA
BECKER, MD, MARTIN S	NORTHAMPTON
BECKER, DO, MICHAEL A	PHILADELPHIA
BECKER, MD, STEPHEN M	FRANKLIN
BECKER, MD, WARD G	BERKS
BECKLEY, MD, ROBERT F	LYCOMING
BECKMAN, DO, IRWIN	ALLEGHENY
BECKWITH, MD, WILLIAM R	DELAWARE
BEDDINGS, MD, ALEJANDRO	BUCKS
BEDFORD, MD, RICHARD A	PHILADELPHIA
BEDGER JR, MD, RICHARD C	CLEARFIELD
BEDNAR, MD, JOHN M	PHILADELPHIA
BEDNAREK, MD, JOSEPH M	PHILADELPHIA
BEDNAREK, MD, THOMAS F	LUZERNE
BEDNARSKI, MD, JEFFREY J	ERIE
BEDNARZ, MD, WALLACE W	LYCOMING
BEDRICK, MD, EDWARD L	PHILADELPHIA
BEDRICK, MD, JEFFREY D	PHILADELPHIA
BEDROSSIAN, MD, E HOWARD	DELAWARE
BEDROSSIAN JR, MD, EDWARD H	DELAWARE
BEDWELL, MD, SCOTT H	CRAWFORD
BEEBY, MD, JAMES L	ERIE
BEEKEY JR, MD, CYRUS E	YORK
BEEM, MD, JOHN W	BERKS
BEERMAN, MD, CURTIS A	CAMBRIA
BEERMAN, MD, HERMAN	PHILADELPHIA
BEERS, MD, KENNETH L	BLAIR
BEERS, MD, MARK H	MONTGOMERY
BEETEL, MD, CHRISTOPHER J	BERKS
BEGG, MD, FRANK R	ALLEGHENY
BEGG, MD, RICHARD J	ALLEGHENY
BEGLEY, MD, CHRISTOPHER J	BLAIR
BEGUM, MD, DILWARA	ALLEGHENY
BEH, MD, WALTER P	MERCER
BEHAR, MD, DAVID	MONTGOMERY
BEHAR, MD, ROBERT D	PHILADELPHIA
BEHBEHANIAN, MD, MAHIN D	DELAWARE
BEHLKE, MD, RICHARD T	LACKAWANNA
BEHR, MD, EDITH D M	MONTGOMERY
BEHREND, MD, BERNARD	PHILADELPHIA
BEHRENDT, MD, RICHARD P	ALLEGHENY
BEHUN, MD, JOSEPH M	ALLEGHENY
BEIDLER, MD, JON G	FRANKLIN
BEILER, MD, DAVID D	MONTOUR
BEITEL JR, MD, ROBERT J	LEHIGH
BEITLE, M DAVID	STUDENT
BEITTEL JR, MD, CHARLES R	DAUPHIN
BEITZEL, MD, JAMES E	SOMERSET
BEIZER, MD, LAWRENCE H	PHILADELPHIA
BEKOE, MD, SETH	ALLEGHENY
BELAK, MD, MICHELE M	STUDENT
BELANGER, MD, KRISTEN A	PHILADELPHIA
BELARDI JR, MD, ALBERT A	LACKAWANNA
BELASCO, MD, JEAN B	PHILADELPHIA
BELASCO, MD, ROBERT N	MONTGOMERY
BELBER, MD, ARTHUR D	MONTGOMERY
BELICH, MD, STEPHEN C	BEAVER
BELKOFF, DO, LAURENCE H	MONTGOMERY
BELL, MD, ALEXANDER L	CENTRE
BELL, MD, ELLA C	PHILADELPHIA
BELL, MD, H CRAIG	MONTGOMERY
BELL, MD, JAMES B	DELAWARE
BELL, MD, LAWRENCE D	BEAVER
BELL, MD, LOUIS D	PHILADELPHIA
BELL, MD, MICHAEL A	LEHIGH
BELL, MD, MICHAEL C	BEAVER
BELL, MD, MICHAEL J	PHILADELPHIA
BELL, MD, RANDALL W	MONTGOMERY
BELL, MD, RICHARD T	BERKS
BELL, MD, ROBERT L	CHESTER
BELL, MD, STEPHEN T	LANCASTER
BELL, MD, STEVEN D	PHILADELPHIA
BELL, MD, THOMAS G	CLEARFIELD
BELL, MD, WILLIAM G	FAYETTE
BELL JR, MD, C RAY	LEBANON
BELL JR, MD, LOUIS M	PHILADELPHIA
BELLA, MD, PARALUMAN	BUTLER
BELLA, MD, ROMEO H	LAWRENCE
BELLAH, MD, RICHARD D	PHILADELPHIA
BELLAIRE, MD, CHERYL R	PHILADELPHIA
BELLANCA JR, MD, GUY L	WESTMORELAND
BELLER, MD, MARTIN L	PHILADELPHIA
BELLES, MD, TERRY A	LYCOMING
BELLIN, MD, HARVEY J	PHILADELPHIA
BELLIN, MD, LISA S	PHILADELPHIA
BELLINGER, MD, E LEE	TIOGA
BELLINO III, MD, PAUL J	MONTOUR
BELLUS, MD, JOHN J	MONTGOMERY
BELMONT, MD, FRANK A	PERRY
BELMONT, MD, HERMAN S	PHILADELPHIA
BELMONT, MD, JONATHAN B	MONTGOMERY
BELMONT, MD, OWEN	PHILADELPHIA
BELOFF, MD, LOUIS	BUCKS
BELOSHITSKAYA, MD, NATALIA	DELAWARE
BELOVICH, MD, DEBBIE L	DAUPHIN
BELSON, MD, ARTHUR B	CHESTER
BELTZ, MD, WILLIAM R	LYCOMING
BEMILLER, MD, CARL	SCHUYLKILL
BEMIS, MD, CHARLES EASTMAN	PHILADELPHIA
BEN-MAIMON, MD, CAROLE S	PHILADELPHIA
BENACK, MD, ANDREA	PHILADELPHIA
BENACK, MD, CARL A	ALLEGHENY
BENAVAGE, MD, MICHAEL F	LEHIGH
BENCIE, MD, DAVID J	CAMBRIA
BENCKART, MD, DANIEL H	ALLEGHENY
BENDER, MD, BARRY L	CLINTON
BENDER, MD, GIL	PHILADELPHIA
BENDER, DO, JOHN D	MONTGOMERY
BENDER, MD, JOSEPH	MONTGOMERY
BENDER, MD, RICHARD J	ALLEGHENY
BENDER, MD, WILLIAM A	FRANKLIN
BENDER JR, MD, FRANK C	DELAWARE
BENDERSKY, MD, GORDON	PHILADELPHIA
BENDITT, MD, MILTON BARRY	PHILADELPHIA
BENDITT, MD, PHILIP L	PHILADELPHIA
BENE, MD, CATHERINE H	YORK
BENEDETTO, DO, ANTHONY V	PHILADELPHIA
BENEDETTO, MD, ERNEST A	PHILADELPHIA
BENEDICT, MD, CATHERINE R	MONTGOMERY
BENEDICT, MD, JOHN H	DAUPHIN
BENEGAS, MD, NANCY M	PHILADELPHIA
BENES III, DO, FRANK J	ERIE
BENESKI, MD, DANIEL A	DELAWARE
BENINATI, MD, DANIEL D	CHESTER
BENJAMIN, MD, DAVID R	ERIE
BENJAMIN, MD, JAMES K	ALLEGHENY
BENJAMIN, MD, KENNETH W	PHILADELPHIA
BENKE, LISA A	STUDENT
BENKINNEY, MD, JAMES A	LUZERNE
BENKO, MD, STEPHEN T	CAMBRIA
BENKOVIC, MD, GREGORY W	MONTOUR
BENNER, MD, PRISCILLA J	MONTGOMERY
BENNER IV, MD, JOHN H	CHESTER
BENNETT, MD, BRUCE K	PHILADELPHIA
BENNETT, MD, HUGH D	PHILADELPHIA
BENNETT, MD, JOEL A	PHILADELPHIA
BENNETT, MD, JOHN A	MONTGOMERY
BENNETT, MD, JOHN T	MONTGOMERY
BENNETT, MD, LEO L	ERIE
BENNETT, MD, PAULA R	WAYNE/PIKE
BENNETT, MD, RAYMOND L	SUSQUEHANNA
BENNETT, MD, ROBERT D	ALLEGHENY
BENNETT IV, MD, JOSEPH S	CHESTER
BENNOV, MD, BENJAMIN Z	BUCKS
BENOIT, MD, CHARLES H	MONTOUR
BENOIT, DO, RICHARD A	LUZERNE
BENOVITZ, MD, BURTON S	LUZERNE
BENSHOFF, MD, ALBERT M	CAMBRIA
BENSIMHON, MD, GEORGES J	NORTHAMPTON
BENSON, MD, DAVID R	CENTRE
BENSON, MD, WILLIAM E	PHILADELPHIA
BENSY, MD, JOSEPH J	ALLEGHENY
BENTIVOGLIO, MD, LAMBERTO G	PHILADELPHIA
BENTLEY, MD, EUGENE A	CHESTER
BENTLEY, RHONDA M A	STUDENT
BENTON, MD, OWEN D	WASHINGTON
BENTZ, MD, CHARLES R	MCKEAN
BENTZ, MD, MICHAEL S	DAUPHIN
BENTZ, MD, RALPH A	DAUPHIN
BENYO, MD, PHILIP J	LUZERNE
BENZ, MD, EDWARD J	NORTHAMPTON
BENZ, MD, ROBERT L	MONTGOMERY
BENZ, MD, THOMAS B	ALLEGHENY
BENZ JR, MD, GEORGE H	ALLEGHENY
BEPLER, MD, CHARLES R	DELAWARE
BERAN, MD, SAMUEL J	PHILADELPHIA
BERARDI, MD, RONALD S	WESTMORELAND
BERBERICH, MD, JOEL J	MONTOUR
BERBERICH, MD, WALTER F	WESTMORELAND
BERCHEN, MD, TOBI M	ALLEGHENY
BERENBAUM, MD, PAUL L	PHILADELPHIA
BERENHOLZ, MD, LEONARD P	PHILADELPHIA
BERESKY, MD, BARNABAS S	ERIE
BERESNY, MD, GERALD M	CENTRE
BEREZ, MD, FRANNE R	WESTMORELAND
BERG, MD, ALAN P	PHILADELPHIA
BERG, MD, GEORGE	ALLEGHENY
BERG, MD, JAMES H	ALLEGHENY
BERG, MD, MORTON D	PHILADELPHIA
BERG, MD, NATHANIEL B	FRANKLIN
BERG, MD, SAUL R	ALLEGHENY
BERGELSON, MD, VICTOR D	MONTGOMERY
BERGER, MD, ALAN	LEHIGH
BERGER, MD, BRUCE C	PHILADELPHIA
BERGER, MD, GARY W	LYCOMING
BERGER, MD, JEFFREY N	ALLEGHENY
BERGER, MD, KARL	CAMBRIA
BERGER, MD, MALCOLM P	ALLEGHENY
BERGER, MD, MARC S	MONROE
BERGER, MD, MARK D	PHILADELPHIA
BERGER, MD, SIMON M	PHILADELPHIA
BERGER, MD, STANLEY R	PHILADELPHIA
BERGER, MD, WINFRIED M	HUNTINGDON
BERGHER, MD, MOISES	PHILADELPHIA
BERGMAN, MD, ELISABETH C	ALLEGHENY
BERGMAN, MD, GARY R	ALLEGHENY
BERGMAN, MD, MARTIN J	DELAWARE
BERGNES, MD, MANUEL A	MONTGOMERY
BERGQUIST, MD, ERICK J	WESTMORELAND
BERGQUIST, GUNNAR E O	STUDENT
BERGREN, MD, ROBERT L	ALLEGHENY
BERGUSON, MD, PAUL D	SCHUYLKILL
BERICH, DO, BRIDGET	ALLEGHENY
BERING, MD, JOSEPH P	LEBANON
BERING, MD, THOMAS G	YORK
BERK, MD, DAVID A	ALLEGHENY

BERK, MD, H RONALD	ALLEGHENY
BERK, MD, HENRY M	MONTGOMERY
BERK, MD, MYLES M	ALLEGHENY
BERK, MD, NATHANIEL G	PHILADELPHIA
BERK, MD, ROBERT L	BUCKS
BERK, MD, THEODORE F	CUMBERLAND
BERKEBILE, MD, PAUL E	ALLEGHENY
BERKENSTOCK, MD, KENNETH G	LANCASTER
BERKEY, MD, KENT E	ALLEGHENY
BERKEY, MD, RICHARD L	ALLEGHENY
BERKHEIMER, MD, GEORGE A	DAUPHIN
BERKHEISER, MD, SAMUEL W	DAUPHIN
BERKMAN, MD, RONALD O	ALLEGHENY
BERKOW, MD, DON A	LANCASTER
BERKOW, MD, ROBERT	MONTGOMERY
BERKOWITZ, MD, ALAN R	LANCASTER
BERKOWITZ, MD, HENRY D	PHILADELPHIA
BERKOWITZ, MD, MORTON I	ALLEGHENY
BERKOWITZ, MD, PETER J	ALLEGHENY
BERKSON, DAVID A	STUDENT
BERKWITS, MD, LELAND	CHESTER
BERLEY, MD, BENJAMIN S	LUZERNE
BERLIN, MD, CHARLES S	ALLEGHENY
BERLIN, MD, ROGER G	MONTGOMERY
BERMAN, MD, ARNOLD T	PHILADELPHIA
BERMAN, MD, DENNIS A	CHESTER
BERMAN, MD, ELI	MONROE
BERMAN, MD, GAIL O	MONTGOMERY
BERMAN, MD, HOWARD J	WESTMORELAND
BERMAN, MD, IRA J	YORK
BERMAN, MD, JEFFREY O	ALLEGHENY
BERMAN, MD, MICHAEL A	ALLEGHENY
BERMAN, MD, PETER D	ALLEGHENY
BERMAN, MD, PETER H	PHILADELPHIA
BERMAN, ROBERT M	STUDENT
BERMUDEZ, MD, ANTONIO G	LUZERNE
BERNACKI, DO, BERNARD J	ALLEGHENY
BERNAL, MD, GUILLERMO J	BUCKS
BERNARDI, DO, MARK M	LUZERNE
BERNARDINO JR, MD, VITALIANO B	BUCKS
BERNAT JR, KARL R	STUDENT
BERNATH JR, MD, ALBERT M	MONTOUR
BERNBAUM, MD, JUDY C	PHILADELPHIA
BERNE, MD, ELLEN S	ALLEGHENY
BERNETT, MD, GARY B	DELAWARE
BERNETT, MD, TIMOTHY M	BRADFORD
BERNHARD, MD, ROBERT A	LANCASTER
BERNIER, MD, GEORGE M	ALLEGHENY
BERNS, MD, LEON L	PHILADELPHIA
BERNSTEIN, MD, A ALEXANDER	LACKAWANNA
BERNSTEIN, MD, BRAD	PHILADELPHIA
BERNSTEIN, MD, DEBORAH R	BUCKS
BERNSTEIN, MD, GUY T	MONTGOMERY
BERNSTEIN, DO, HENRY H	BUCKS
BERNSTEIN, MD, LARRY	PHILADELPHIA
BERNSTEIN, MD, MARK H	BUCKS
BERNSTEIN, MD, ROBERT W	ALLEGHENY
BERNSTINE, MD, EARL L	YORK
BERNSTINE, MD, J BERNARD	PHILADELPHIA
BERONILLA JR, MD, HILARION A	FAYETTE
BERRY, MD, GEORGE J	ALLEGHENY
BERRY, MD, GERARD T	PHILADELPHIA
BERRY, MD, MARCOS A	PHILADELPHIA
BERSCHLING, MD, CHESTER M	ALLEGHENY
BERTA, MD, JULIUS W	WARREN
BERTOLETTE, MD, RICHARD D	BERKS
BERTRAM, MD, HORST N	LEBANON
BERTRAM, MD, KARL R	TIOGA
BERTSCH, MD, ALBERT M	SUSQUEHANNA
BERTSCH, MD, MICHELLE M	MONTGOMERY
BERWICK, MD, EVELYN S	ALLEGHENY
BERWISH, MD, NEIL J	PHILADELPHIA
BESSELMAN, MD, DAVID M	DAUPHIN
BEST, MD, JOHN W	YORK
BESWICK, MD, DAVID R	LUZERNE
BETESH, MD, JOEL S	PHILADELPHIA
BETHALA, MD, YASHASHREE L	PHILADELPHIA
BETHUNE, MD, D SCOTT	VENANGO
BETTINGER, MD, ROBERT	ALLEGHENY
BETTS, DO, BROOKS	NORTHAMPTON
BETTS, MD, CHARLES R	ALLEGHENY
BETTS, MD, EUGENE K	PHILADELPHIA
BETTS, DO, WILLIAM E	LANCASTER
BETZ, MD, LOUIS H	UNION
BETZ, MD, RANDAL R	PHILADELPHIA
BETZ, MD, WILLIAM R	ERIE
BEUMONT, MD, MARIA G	PHILADELPHIA
BEUTLER, MD, WILLIAM J	DAUPHIN
BEVERLY, MD, AVERY W	PHILADELPHIA
BEVERLY JR, MD, ROLAND S	PHILADELPHIA
BEVILACQUA, MD, DANIEL F	ADAMS
BEVILACQUA, MD, JOHN E	PHILADELPHIA
BEVILACQUA, MD, LORRAINE B	ALLEGHENY
BEYER, MD, DAVID W	WESTMORELAND
BEYER, MD, H JEANNE	CLEARFIELD
BEYER III, MD, FREDERICK C	LANCASTER
BEYER JR, MD, FRANCIS D	WESTMORELAND
BEYER JR, MD, KARL H	PHILADELPHIA
BEZIER, MD, JEFFREY L	ALLEGHENY
BHAGAT, MD, PRAGNA R	MONROE
BHAGAT, MD, RAJESH G	MONROE
BHAGWANANI, MD, DRUPADI G	ALLEGHENY
BHAKTA, SANJAY C	STUDENT
BHANDERI, MD, KESHAVJI N	LUZERNE
BHARILL, MD, PARTH S	ALLEGHENY
BHARUCHA, MD, SHERNAVAZ D	DAUPHIN
BHASIN, MD, ARVIND	BEAVER
BHAT, MD, ELEANOR	STUDENT
BHATIA, MD, SHYAMSUNDER	MONTOUR
BHATNAGAR, MD, YUDHISHTER M	CLARION
BHATT, MD, DEEPAK L	PHILADELPHIA
BHATT, MD, DRUPAD	MONROE
BHATT, MD, NARESH I	WASHINGTON
BHATT, MD, PRAFUL U	CLINTON
BHAYANI, MD, SHABIR A	MCKEAN
BHE, MD, H KWAN	CARBON
BHUTANI, MD, VINOD K	PHILADELPHIA
BHUTTA, MD, OMAR I	ALLEGHENY
BHYUN, MD, DAE SOO	YORK
BIALAS, MD, HENRY N	BERKS
BIALAS, MD, ROBERT F	DELAWARE
BIANCA III, MD, VINCENT C	LACKAWANNA
BIANCARELLI, MD, EDMUND J	LACKAWANNA
BIANROSA, MD, JOHN J	PHILADELPHIA
BICKEL, MD, REBECCA L	ALLEGHENY
BIDULA, MD, LEO P	ALLEGHENY
BIDULA, MD, MAUREEN M	ALLEGHENY
BIEBUYCK, MD, JULIEN F	DAUPHIN
BIEDERMAN, MD, ROBERT W W	DAUPHIN
BIELE, MD, FLORA H	PHILADELPHIA
BIEMULLER, MD, MARTHA L	PHILADELPHIA
BIEN-AIME, MD, MICHAEL J	PHILADELPHIA
BIENIEK, MD, MARZENA L	NORTHAMPTON
BIENIEK, MD, RUSSELL B	ERIE
BIERER, MD, EDWARD D	ARMSTRONG
BIERI, MD, JOHN W	DAUPHIN
BIERMANN, MD, WILLIAM A	PHILADELPHIA
BIESINGER, MD, GEORGE J	BLAIR
BIETER-SCHULTZ, DO, DEBORAH	DELAWARE
BIGGS, DO, ROBERT H	NORTHAMPTON
BIGLAN, MD, ALBERT W	ALLEGHENY
BIGLER, MD, ROBERT D	PHILADELPHIA
BIGLEY, MD, JOSEPH R	PHILADELPHIA
BIGOS, MD, EDWARD T	BERKS
BIKLE, MD, CHARLES A	FRANKLIN
BIKLE, MD, H DWIGHT	ADAMS
BIKOWSKI, MD, JOSEPH B	ALLEGHENY
BILANIUK, MD, LARISSA T	PHILADELPHIA
BILBAO, MD, ANGEL	ALLEGHENY
BILDER, MD, MATTHEW B	BERKS
BILES, MD, WILLIAM	MONTOUR
BILINSKI, MD, CAROL A	ALLEGHENY
BILKO, MD, THOMAS E	LUZERNE
BILLER, MD, AIMEE B	ALLEGHENY
BILLIG, MD, RUTH A	PHILADELPHIA
BILLON, MD, ANDREW	INDIANA
BILSKY, MD, ALAN CHARLES	PHILADELPHIA
BINAKONSKY, MD, HARRY S	ALLEGHENY
BINDER, MD, ERIC J	YORK
BINDIE, MD, RICHARD P	SCHUYLKILL
BINGHAM, MD, RODNEY S	CENTRE
BINIAURISHVILI, MD, RAOUL G	PHILADELPHIA
BINNICK, MD, STEVEN A	MONTGOMERY
BINNS, MD, VERONICA	FAYETTE
BINSTOCK, MD, HAROLD	ALLEGHENY
BIRD, MD, LUIS J	PHILADELPHIA
BIRD, MD, RUSSELL J	LANCASTER
BIRD, SHARON R	STUDENT
BIRK, MD, CATHERINE M	ALLEGHENY
BIRMAHER, MD, BORIS	ALLEGHENY
BIRNBAUM, MD, MICHAEL D	PHILADELPHIA
BIRRELL, MD, DONALD G	ALLEGHENY
BIRSIC, MD, WILLIAM I	ALLEGHENY
BISACCO, MD, STEPHEN J	BLAIR
BISCHOF, DO, LEE R	ALLEGHENY
BISCHOF, MD, RALPH O	PHILADELPHIA
BISER, SETH A	STUDENT
BISHAI, MD, DAVID M	PHILADELPHIA
BISHOP, MD, DAVID W	BLAIR
BISHOP, MD, DEBORAH E	ERIE
BISHOP, MD, JERRY W	BERKS
BISHOP, MD, ROBERT P	MONTGOMERY
BISHOP, MD, WAYNE E	CENTRE
BISHOW, MD, I RALPH	PHILADELPHIA
BISIGNANI, MD, GABRIELLA M	LACKAWANNA
BISIGNANI, MD, GEOFFREY J	DAUPHIN
BISSET JR, MD, JAMES F	NORTHAMPTON
BITAR III, H JOSEPH	STUDENT
BITETTO, MD, NICOLA	BERKS
BITMAN, MD, HAROLD L	PHILADELPHIA
BITMAN, MD, JOSEPH	PHILADELPHIA
BITTERLY, MD, THOMAS J	MONTOUR
BIUCKIANS, MD, EDWARD	BUCKS
BIUSO, MD, THOMAS J	LANCASTER
BIX, MD, NADJA D	PHILADELPHIA
BIZOUSKY, DO, FRANKLIN P	BLAIR
BIZOUSKY, MD, FRANKLIN S	JEFFERSON
BIZUP, MD, THOMAS	SCHUYLKILL
BJORKLUND, MD, MARK D	CUMBERLAND
BLACK, MD, HOWARD M	BLAIR
BLACK, MD, JUDITH E	ALLEGHENY
BLACK, MD, KEVIN P	DAUPHIN
BLACK, MD, MARTIN	PHILADELPHIA
BLACK, MD, MICHAEL G	PHILADELPHIA
BLACK, MD, MILTON H	ALLEGHENY
BLACK, MD, PERRY	PHILADELPHIA
BLACK, DO, SAMUEL J	BUTLER
BLACK JR, MD, HARRY A	ALLEGHENY
BLACK JR, MD, WILLIAM A	LACKAWANNA
BLACKBURN, MD, LAWRENCE F	WESTMORELAND
BLACKBURN, DO, R RANDALL	FAYETTE
BLACKBURN JR, MD, LAURENCE H	BUCKS
BLACKSMITH, DO, JAMES E	DAUPHIN
BLACKSMITH, DO, WILLIAM A	DAUPHIN
BLACKSMITH JR, MD, GARY L	CUMBERLAND
BLAHA, GREGORY R	STUDENT
BLAIR, MD, ALBERT J	ALLEGHENY
BLAIR, MD, FRANK W	PHILADELPHIA
BLAISDELL, MD, C THEODORE	LEHIGH
BLAISDELL, MD, THEODORE A	LANCASTER
BLAKE, MD, DOUGLAS R	LEHIGH
BLAKE, MD, HU A	PHILADELPHIA
BLAKE, DO, JAMES S	PHILADELPHIA
BLAKE, MD, KARL E	ALLEGHENY
BLAKE, MD, PAUL O	DELAWARE
BLAKELEY, DO, ANN K	ALLEGHENY
BLAKESLEE, DO, COLSON E	JEFFERSON
BLAKLEY, MD, JOHN B	ALLEGHENY
BLANCH, MD, JOSEPH J	PHILADELPHIA
BLAND, MD, C BRINLEY	PHILADELPHIA
BLANDON, MD, RODOLFO J	PHILADELPHIA
BLANK, MD, SAMUEL	PHILADELPHIA
BLANKENSHIP, MD, JAMES C	MONTOUR
BLANKENSHIP, MD, LARRY L	BEAVER
BLANZACO, MD, ANDRE C	PHILADELPHIA
BLASIOL, DO, JOSEPH J	LEHIGH
BLASS, MD, DAVID C	FAYETTE
BLATCHLEY, MD, DONALD M	WESTMORELAND
BLATT, MD, BRUCE I	MONTGOMERY
BLATT, MD, MARK A	PHILADELPHIA
BLAUM SR, MD, LOUIS C	LUZERNE
BLAUSER, MD, ROBERT B	BERKS
BLAUTH, JEANETTE M	STUDENT
BLAZER, MD, DAVID J	LEBANON
BLEACHER, MD, JOHN C	DAUPHIN
BLECHER, MD, MARK H	PHILADELPHIA
BLECKER, MD, DAVID	YORK
BLECKER, MD, UWE	PHILADELPHIA
BLEDAY, MD, RAYMOND M	MONTOUR
BLEEDEN, MD, EDWARD M	DELAWARE
BLEI, REBECCA L	STUDENT
BLEICHER, MD, RICHARD J	STUDENT
BLEIMAN, MD, MICHAEL I	MONTGOMERY
BLENDER, DO, BURTON	PHILADELPHIA
BLESHMAN, MD, MICHAEL H	CHESTER
BLEWETT, MD, CHARLES H	POTTER
BLEWITT, MD, GEORGE A	PHILADELPHIA
BLEZNAK, MD, AARON D	CENTRE
BLILEY, MD, KIRK S	ALLEGHENY
BLINDER, MD, JEFFREY S	LEHIGH
BLINKOFF, MD, BARRY A	PHILADELPHIA
BLINN, MD, DAVID L	ALLEGHENY
BLISARD, DEANNA M	STUDENT
BLOCH, MD, ROBERT S	NORTHAMPTON
BLOCK, MD, MARIAN R	ALLEGHENY
BLOCK, MD, ROBERT A	PHILADELPHIA
BLOCK, MD, ROBERT C	ALLEGHENY
BLOCK, MD, RONALD M	DELAWARE
BLOCK, MD, STEVEN	BUCKS
BLOCKSTEIN, MD, ROBERT S	ALLEGHENY
BLODGETT JR, MD, RANDOLPH C	MONTOUR
BLOES, MD, WALTER S	LACKAWANNA
BLOISO, MD, GLENN T	LYCOMING
BLOM, MD, BOHEN M F	LYCOMING
BLOM, MD, JOHANNES	LYCOMING
BLOMAIN, MD, E WILLIAM	LACKAWANNA
BLOMAIN, MD, ERIC W	LACKAWANNA
BLOOD JR, MD, JOSEPH B	BRADFORD
BLOOM, MD, BENJAMIN H	PHILADELPHIA
BLOOM, MD, BRIAN P	DAUPHIN
BLOOM, MD, JOSEPH	PHILADELPHIA
BLOOM, MD, LAWRENCE H	PHILADELPHIA
BLOOM, MD, MARVIN A	WESTMORELAND
BLOOM, MD, SANDRA L	BUCKS
BLOOMGARDEN, MD, RAPHAEL T	PHILADELPHIA
BLOOMSTINE, MD, MARK T	ERIE
BLORE JR, MD, JAMES P	BUCKS
BLOSCHICHAK, MD, ANDREW	ADAMS
BLOSE, MD, LINDA K	NORTHAMPTON
BLOUGH, MD, LELAND S	ALLEGHENY
BLUE, MD, TODD M	PHILADELPHIA
BLUEMLE JR, MD, LEWIS W	PHILADELPHIA
BLUESTEIN, MD, DAVID D	ALLEGHENY
BLUESTEIN, MD, HAZEL M	MONTGOMERY
BLUM, MD, LARRY W	PHILADELPHIA
BLUM, MD, RICHARD H	LUZERNE
BLUMBERG, MD, ALEXANDER W	LYCOMING
BLUMBERG, MD, BARUCH S	PHILADELPHIA
BLUMBERG, MD, MYRON L	PHILADELPHIA
BLUME, MD, ROBERT P	ALLEGHENY
BLUMENFELD, MD, LOUIS C	ALLEGHENY
BLUMENSCHEIN, MD, GERTRUDE	FAYETTE
BLUMENTHAL, MD, ANDREW R	MONTGOMERY
BLUMENTHAL, MD, JEFFREY R	BUCKS
BLUMENTHAL, MD, MELVIN S	BUCKS
BLUMENTHAL, MD, NEIL C	NORTHAMPTON
BLUMENTHAL, MD, SHERRY L	PHILADELPHIA
BLUMSTEIN, MD, CHARLES G	MONTGOMERY
BLYDENBURGH, MD, SUSAN M	CHESTER
BLYTHE, MD, PEGGY J	WASHINGTON
BOAL, MD, ERWIN S	BEAVER
BOAL JR, MD, JOHN H	BEAVER
BOBAK, MD, WLADYSLAW	FAYETTE
BOBBY, DO, JOHN L	ALLEGHENY
BOBECK, MD, JOSEPH J	LUZERNE
BOBEK, MD, FRANCIS B	COLUMBIA
BOBICK, MD, FRANK	CARBON
BOBIN, MD, JOHN J	YORK
BOBMAN, MD, DAVID E	DELAWARE
BOBRIN, BRAD D	STUDENT
BOBRIN, DO, MARSHALL C	PHILADELPHIA
BOCCAGNO, MD, PHILLIP A	LACKAWANNA
BOCHER, MD, JACK	CHESTER
BOCK, MD, WILLIAM M	CUMBERLAND
BODE JR, MD, FREDERICK W	ALLEGHENY
BODEK, MD, ALVIN M	ALLEGHENY
BODEK, MD, KENNETH E	ALLEGHENY
BODENDORFER, KARL D	STUDENT
BODMER, MD, MERAL O	NORTHMBRLAND
BODNER, MD, DARYL G	LANCASTER
BOEHME, MD, KEVIN G	ALLEGHENY
BOELLNER, MD, ALICIA A	PHILADELPHIA
BOERIO, DO, MARGARET R	WESTMORELAND
BOETTLER, MD, MARK A	ALLEGHENY
BOGDANOFF, MD, BRUCE M	DELAWARE
BOGDEWIC, MD, THOMAS A	ALLEGHENY
BOGER, MD, WILLIAM P	PHILADELPHIA
BOGERT, DO, ARTHUR EDWIN	PHILADELPHIA
BOGERT, EUGENIA-PAULITA	STUDENT
BOGUCKI, MD, EDWIN I	DELAWARE
BOGUCKI, MD, FRED R	PHILADELPHIA
BOGYI, MD, ANTONIA M	ALLEGHENY
BOHATIUK, MD, GEORGE M	ERIE
BOHEEN, ERICA A	STUDENT
BOHLENDER, MD, GEORGE P	ERIE
BOHM-VELEZ, MD, MARCELA	ALLEGHENY
BOHNENBLUST, MD, WALTER R	SCHUYLKILL
BOHNENBLUST JR, MD, WALTER R	BERKS
BOHNER, MD, MARY F	ALLEGHENY
BOHONYI, MD, WILLIAM A	DAUPHIN
BOHRI, MD, JAMES D	CARBON
BOKA, MD, SUZANNA P	MONTOUR
BOKER, MD, STEVEN M	LAWRENCE
BOLAND, MICHAEL V	STUDENT
BOLAND, MD, STANLEY W	LACKAWANNA
BOLAND JR, MD, FRANCIS B	BUCKS
BOLANOVICH, MD, LESTER J	ALLEGHENY
BOLANOWSKI, MD, DEBORAH J	BUCKS
BOLDEN, MD, MARY C	ALLEGHENY
BOLDEN, MD, PATRICK T	PERRY
BOLDEN, MD, RICHARD O	WESTMORELAND
BOLINE, MD, GEORGE B	DAUPHIN
BOLINGER, MD, MARK S	HUNTINGDON
BOLLARD, MD, EDWARD R	DAUPHIN
BOLLINGER, MD, JAMES R	CHESTER
BOLMANN, MD, ANDREW R	MONTGOMERY
BOLNO, DO, CHARLES M	PHILADELPHIA
BOLOTIN, MD, JOSEPH H	MERCER
BOLUS, MD, CHARLES M	LACKAWANNA
BOMALASKI, MD, JOHN S	CHESTER
BOMZE, MD, JEFFREY P	MONTGOMERY
BONACUM, DO, MICHAEL G	MONTOUR
BONAKDAR-POUR, MD, AKBAR	PHILADELPHIA
BONANNI, MD, LORETTA D	CHESTER
BONAVENTURA, MD, MARGUERITE	ALLEGHENY
BONCHEK, MD, LAWRENCE I	LANCASTER
BOND, MD, JEFFREY B	MONTGOMERY
BONDI, MD, EDWARD EDGE	PHILADELPHIA
BONDI, MD, RICHARD P	ALLEGHENY
BONDY, MD, THOMAS J	CAMBRIA
BONE, LINDA J	STUDENT
BONEKEMPER, MD, THOMAS W	LEHIGH
BONESSI, MD, JAMES V	ALLEGHENY
BONESSI, EXEC SEC, COBY	WASHINGTON
BONFIGLIO, MD, RICHARD P	CHESTER
BONI JR, MD, DINO R	WASHINGTON
BONIFACE, MD, DOLORES J	ALLEGHENY
BONITA, MD, LOUIS B	LUZERNE
BONITA, MD, RAPHAEL	LUZERNE
BONNEAU, MD, AMY J	DAUPHIN
BONNER, MD, DENNIS J	BUCKS
BONNER, MD, EILEEN M	MONTGOMERY
BONNER, MD, JAMES F	PHILADELPHIA
BONNER, MD, JAMES J	BERKS
BONNER, MD, MARY J	BERKS
BONNER, MD, ROBERT E	PHILADELPHIA
BONNER, MD, WILLIAM F	BUCKS
BONNER JR, MD, FRANCIS J	MONTGOMERY
BONO, MD, JOHN	ARMSTRONG
BONOAN, MD, JOSE TADEO M	PHILADELPHIA
BONONI, MD, PATRICIA L	ALLEGHENY
BONONI, MD, PAULA A	MONTGOMERY
BONOS III, MD, CHARLES T	LEHIGH
BONTEMPO, MD, FRANKLIN A	BEAVER
BONUCCI, MD, BRUNO L	FAYETTE
BONWICH, JANINA B	STUDENT
BOO, MD, KI T	LEHIGH
BOOGAARD, MD, RONALD G	LEBANON
BOOK, MD, MORRIS M	BEAVER
BOOKERT, MD, CHARLES C	ALLEGHENY
BOONE, MD, EDGAR A	WESTMORELAND
BOONE, MD, JOY L	WESTMORELAND
BOONIN, MD, ALAN	LUZERNE
BOONSWANG, MD, PRICHA	NORTHAMPTON
BOONVISUDHI, MD, THUMRONG	FAYETTE
BOOR, MD, JOHN W	DELAWARE
BOORSE, MD, RICHARD C	LEHIGH

BOOTH, ALEXANDRA E	STUDENT
BOOTH, MD, KEVIN R	DELAWARE
BOOTH JR, MD, ROBERT E	PHILADELPHIA
BOOVA, MD, ROBERT S	DELAWARE
BORAH, MD, BISHNU C	BUCKS
BORAN, MD, ROBERT P	SCHUYLKILL
BORAN, MD, THOMAS V	SCHUYLKILL
BORANS, STACY M	STUDENT
BORCZON, MD, DENNIS P	ERIE
BORDEN, DO, STANLEY J	MONTGOMERY
BORECKY, MD, DAVID C	CAMBRIA
BOREEN, MD, STUART M	NORTHAMPTON
BORETSKY, MD, HARRY	ALLEGHENY
BORETSKY, MD, ROBERT H	ALLEGHENY
BORGATTA, MD, LOUIS	BERKS
BORGER, MD, LEE J	WARREN
BORGIA, MD, FRANK A	ALLEGHENY
BORGMANN-WINTER, KARIN	STUDENT
BORIK, DO, ANNE	ALLEGHENY
BORJA, MD, ROGELIO I	BUTLER
BORKOVIC, MD, EMBRIE J	BEAVER
BORKOW, MD, JOEL E	CAMBRIA
BORKOWSKI, MD, WINSLOW J	PHILADELPHIA
BORN, MD, CHRISTOPHER T	PHILADELPHIA
BORN, MD, MICHAEL W	YORK
BORNFRIEND, MD, LYNN A	PHILADELPHIA
BORNS, MD, PATRICIA F	PHILADELPHIA
BORNT, MD, MARSHA D	YORK
BOROFSKY, MD, MICHAEL A	BERKS
BORON, MD, ROBERT J	CLEARFIELD
BORON, MD, RONALD L	ALLEGHENY
BORON, MD, STELLA M	INDIANA
BOROUMAND, MD, MASOOD	CAMBRIA
BOROW, MD, LAWRENCE S	PHILADELPHIA
BOROW, MD, SYDNEY	PHILADELPHIA
BORRA, MD, BOLLIAH	LUZERNE
BORROR, MD, MEGAN J	DAUPHIN
BORTIN, MD, LEONARD	PHILADELPHIA
BORTNER, MD, DONALD L	YORK
BORTS, MD, FREDERICK T	BUCKS
BORTZ, MD, DONALD W	WESTMORELAND
BORUS, MD, HARRY E	ALLEGHENY
BORYS, MD, DAVID J	DAUPHIN
BOSACCO, MD, DAVID N	DELAWARE
BOSACCO, MD, STEPHEN J	PHILADELPHIA
BOSCHA, MD, KENNETH W	WESTMORELAND
BOSCHI, MD, ALESSANDRO S	CARBON
BOSCIA, MD, JEROME A	PHILADELPHIA
BOSELLI, MD, BRUCE D	BRADFORD
BOSLEY, MD, THOMAS M	PHILADELPHIA
BOSSARD, MD, VALERIE J	PHILADELPHIA
BOSSART, MD, BARBARA A	ERIE
BOSSE, MD, MILTON D	ALLEGHENY
BOSSIO, ADRIENNE E	STUDENT
BOTEK, MD, ALISON A	PHILADELPHIA
BOTELHO, EXEC SEC, JANEANN	JEFFERSON
BOTHWELL, MD, WILLIAM N	MONTGOMERY
BOTKIN, MD, LESTER H	ALLEGHENY
BOTROS, MD, MAUREEN R	PHILADELPHIA
BOTTGER, MD, DAVID A	DELAWARE
BOUCHER, MD, ROBERT M	DELAWARE
BOUCHER, MD, WILLIAM F	LEHIGH
BOUGH, MD, IRVIN DAVID	PHILADELPHIA
BOUVIER, MD, MARIANNE	ALLEGHENY
BOVE, MD, FRANK A	PHILADELPHIA
BOVE, MD, RICHARD L	PHILADELPHIA
BOVE III, DO, JAMES D	DELAWARE
BOWEN, MD, A'DELBERT	ALLEGHENY
BOWEN, MD, ANNE C	CHESTER
BOWEN, MD, KAREN A	YORK
BOWEN JR, MD, FRANK W	PHILADELPHIA
BOWEN JR, MD, THALES	MONTGOMERY
BOWER, MD, DOUGLAS J	CUMBERLAND
BOWER, MD, JAMES H	DAUPHIN
BOWER, MD, JAMES N	LAWRENCE
BOWER, MD, JOHN R	BERKS
BOWER, MD, ROBERT	PHILADELPHIA
BOWER SR, MD, JOHN R	BERKS
BOWERS, MD, BARBARA A	YORK
BOWERS, MD, CYNTHIA M	ERIE
BOWERS, MD, DAVID N	BERKS
BOWERS, MD, LEROY W	BLAIR
BOWERS, MD, PAUL A	PHILADELPHIA
BOWERS, MD, RICHARD A	ALLEGHENY
BOWERS, MD, ROBERT M	TIOGA
BOWERS, MD, STEVEN K	ERIE
BOWLES, MD, LAWRENCE T	PHILADELPHIA
BOWMAN, MD, HERBERT S	DAUPHIN
BOWMAN, MD, JOHN H	LANCASTER
BOWMAN, MD, MICHAEL W	ALLEGHENY
BOWMAN, MD, ROBERT G	WESTMORELAND
BOWMAN JR, MD, DOUGLAS F	MCKEAN
BOXER, MD, ARTHUR D	MONTGOMERY
BOXER, MD, LOUIS M	PHILADELPHIA
BOYADJIS, MD, TERRENCE A	PHILADELPHIA
BOYD, MD, KENNETH J	DELAWARE
BOYD, MD, ROBERT L	DELAWARE
BOYD, MD, WILLIAM J	DAUPHIN
BOYD III, MD, THOMPSON H	PHILADELPHIA
BOYEK, MD, MICHAEL F	BRADFORD
BOYEK, MD, TIMOTHY J	CHESTER
BOYER, MD, GEORGE S	LEHIGH
BOYER, MD, RANDAL A	PHILADELPHIA
BOYER, MD, WALTER E	VENANGO
BOYKIW, MD, MARK E	INDIANA
BOYLAN, MD, JAMES J	NORTHAMPTON
BOYLAN JR, MD, RAYMOND J	ALLEGHENY
BOYLE, MD, BRIAN F	WESTMORELAND
BOYLE, MD, DENIS A	DELAWARE
BOYLE, MD, EILEEN M	ALLEGHENY
BOYLE, MD, HUGH G	LUZERNE
BOYLE, MD, JAMES W	ALLEGHENY
BOYLE, MD, L EAMONN	YORK
BOYLE, MD, MARY C	ALLEGHENY
BOYLE, MD, RICHARD C	ERIE
BOYLE, MD, RONALD N	CAMBRIA
BOYLE, MD, SHERRY M	PHILADELPHIA
BOYLE, MD, WILLIAM H	LUZERNE
BOYLE JR, MD, DENIS A	DELAWARE
BOYLER, MD, LAWRENCE J	FRANKLIN
BOYLSTON, MD, BEDFORD F	DAUPHIN
BOYNTON, MD, ROBERT F	PHILADELPHIA
BOYSEN, MD, HOMER	SCHUYLKILL
BOZENTKA, MD, DAVID J	PHILADELPHIA
BOZIC, MD, ALBERT F	LYCOMING
BRAAT, MD, KEVIN	PHILADELPHIA
BRABAZON, DO, JOHN F	LANCASTER
BRABENDER, MD, REBECCA R	ALLEGHENY
BRACE, MD, FREDERICK H	PHILADELPHIA
BRACKBILL, MD, ELIZABETH J	BERKS
BRACKIN, MD, GEORGE G	BUCKS
BRACKIN, MD, PHILLIP S	MONTGOMERY
BRADEN, MD, GEOFFREY L	PHILADELPHIA
BRADEN JR, MD, FRANK R	ALLEGHENY
BRADFORD, MD, BRADLEY J	ALLEGHENY
BRADFORD, MD, JOHN D	CHESTER
BRADFORD, MD, PAUL L	MONTGOMERY
BRADFORD, DO, WILLIAM C	LANCASTER
BRADLEY, MD, BETTY H	ALLEGHENY
BRADLEY, DO, BRUCE A	ALLEGHENY
BRADLEY, ELIZABETH A	STUDENT
BRADLEY, MD, JAMES P	ALLEGHENY
BRADLEY, DO, JOSEPH J	MONTGOMERY
BRADLEY, LORELLE E	STUDENT
BRADLEY, MD, ROBERT M	ALLEGHENY
BRADLEY, MD, RUSSELL S	ALLEGHENY
BRADLEY, MD, SAMUEL M	CAMBRIA
BRADLEY, MD, VERNON F	BLAIR
BRADLEY, MD, WILLIAM L	WESTMORELAND
BRADLEY JR, MD, ROBERT H	PHILADELPHIA
BRADLEY JR, MD, WILLIAM P	ALLEGHENY
BRADY, MD, DOUGLAS F	WESTMORELAND
BRADY, DO, J GREGG	LEHIGH
BRADY, JODI L	STUDENT
BRADY, MD, LUTHER W	PHILADELPHIA
BRAFFMAN, MD, MICHAEL N	PHILADELPHIA
BRAGDON, MD, ROBERT W	ALLEGHENY
BRAHMAKULAM, MD, PAUL M	MIFFLIN/JUNIATA
BRAHOS, MD, ANTHONY G	CLEARFIELD
BRAITMAN, MD, ROBERT A	PHILADELPHIA
BRALLIER, MD, HUGH W	WESTMORELAND
BRALOW, MD, S PHILIP	PHILADELPHIA
BRALOW, DO, SCOTT A	PHILADELPHIA
BRAMBLETT, GREGORY T	STUDENT
BRAMOWITZ, MD, ALAN D	ALLEGHENY
BRANAS, DO, JOHN A	LANCASTER
BRANCATO, MD, CHRISTOPHER R	NORTHMBRLAND
BRANCAZIO, DO, PASQUALE	DELAWARE
BRAND, MD, CAROL E	ALLEGHENY
BRANDFASS, MD, W TAYLOR	DELAWARE
BRANDMAN, MD, ITA S	PHILADELPHIA
BRANDON, MD, JOHN M	WASHINGTON
BRANDON, MD, MILTON B	JEFFERSON
BRANDSTETTER, MD, LOUIS H	ALLEGHENY
BRANDT, MD, DOUGLAS M	MERCER
BRANDT, MD, JOHN P	CLINTON
BRANDT, MD, ROBERT I	BEAVER
BRANDY, MD, DOMINIC A	ALLEGHENY
BRANIN, DO, BRUCE K	LACKAWANNA
BRANNAC, MD, PATRICK G	FRANKLIN
BRANSCUM, MD, GEORGE P	CUMBERLAND
BRANT, MD, ARTHUR M	MONTGOMERY
BRANT, MD, CARL E	WESTMORELAND
BRASILE, DO, DOMENICK J	ERIE
BRASLOW, MD, NORMAN H	DELAWARE
BRAU, MD, ALAN S	NORTHAMPTON
BRAUN, MD, JEAN B	FAYETTE
BRAUN, MD, MARIA A	BERKS
BRAUN, MAX	STUDENT
BRAUN, STEPHANIE M	STUDENT
BRAUN, EXEC SEC, VICTORIA	BUTLER
BRAUN III, MD, WILLIAM P	NORTHAMPTON
BRAUNEGG JR, MD, PAUL W	LYCOMING
BRAUNFELD, DO, ROBERT	DELAWARE
BRAUNSTEIN, MD, LARRY	PHILADELPHIA
BRAV, MD, SOLOMON S	PHILADELPHIA
BRAVEMAN, MD, BERNARD L	ALLEGHENY
BRAVETTE, MD, BARRY A	PHILADELPHIA
BRAY, MD, JOHN P	BLAIR
BRAY, MD, JOHN S	DAUPHIN
BRAY, MD, JOSHUA C	MONTGOMERY
BRAY, MD, SUSAN H	PHILADELPHIA
BRAYMAN, MD, KENNETH L	PHILADELPHIA
BRAZEL, MD, JOSEPH F	CUMBERLAND
BRAZZO, MD, BRIAN G	PHILADELPHIA
BREAKSTONE, MD, LOUISE A	LUZERNE
BREARLY, MD, WAYNE R	CHESTER
BRECHER, MD, EUGENE	PHILADELPHIA
BRECHER, MD, JEFFREY A	BUCKS
BRECKENRIDGE, MD, JOHN W	MONTGOMERY
BREE, DO, STANTON A	CHESTER
BREECKER, MD, STEVEN W	PHILADELPHIA
BREEN, MD, GREGORY	STUDENT
BREIN, MD, KENNETH R	YORK
BREINER, JEFFREY H	STUDENT
BREITFELD, MD, VOLKER	ALLEGHENY
BREN, DO, DEBORAH A	LEHIGH
BRENEMAN, MD, JOHN W	FRANKLIN
BRENES, MD, GILBERT	ALLEGHENY
BRENMAN, MD, ARNOLD K	PHILADELPHIA
BRENMAN, MD, SCOTT A	PHILADELPHIA
BRENNAN, DO, EDWARD C	DAUPHIN
BRENNAN, MD, MARK D	PHILADELPHIA
BRENNAN, MD, RICHARD E	BEAVER
BRENNAN, MD, ROBERT W	DAUPHIN
BRENNAN JR, MD, EDWARD J	DELAWARE
BRENNEMAN, MD, PAUL G	BUCKS
BRENNEMAN, MD, RICHARD E	NORTHAMPTON
BRENNEN, MD, ROBERT F	LEHIGH
BRENNER, MD, BARRY S	PHILADELPHIA
BRENNER, MD, LOUIS O	DAUPHIN
BRENNER, DO, RICHARD P	PHILADELPHIA
BRENT, MD, BRADLEY H	ALLEGHENY
BRENT, MD, LAWRENCE B	ALLEGHENY
BRENT, MD, NANCY B	ALLEGHENY
BRERETON, MD, HARMAR D	LACKAWANNA
BRERETON, MD, WILLIAM F	ERIE
BRESLIN, MD, JOSEPH A	LANCASTER
BRESLIN, MD, KENNETH S	BUCKS
BRESS, MD, ALAN N	ALLEGHENY
BRESS, MD, JAMES C	ALLEGHENY
BRESSLER, MD, LAWRENCE P	BUCKS
BRESSLER, MD, WILLIAM L	HUNTINGDON
BREST, MD, ALBERT N	PHILADELPHIA
BRESTICKER, MD, DAVID H	LYCOMING
BRETHAUER JR, MD, EDWARD A	ALLEGHENY
BRETT III, MD, GEORGE W	BEAVER
BRETZ, MD, KAREN A	LEHIGH
BREVETTA, MD, RICHARD J	MERCER
BRIAN, JAMES M	STUDENT
BRICKER, DO, ROBERT D	SCHUYLKILL
BRICKER, MD, SAMUEL Q	FRANKLIN
BRICKHOUSE, MD, HERMAN M	LYCOMING
BRICKLEY, MD, KENNETH S	CLINTON
BRICKLEY, MD, RICHARD S	WESTMORELAND
BRICKNELL, MD, PAUL P	DAUPHIN
BRIDE, DO, THOMAS P	YORK
BRIDENBAUGH, MD, G ALAN	YORK
BRIDENBAUGH, MD, ROBERT P	BLAIR
BRIDGE, MD, RAYMOND J	ERIE
BRIDGES, MD, BRYAN C	CENTRE
BRIER, MD, PETER M	DAUPHIN
BRIGHAM, MD, MARK P	CHESTER
BRIGHAM, MD, ROBERT A	BERKS
BRIGHT, ROBERT C	STUDENT
BRIGHTON, MD, CARL T	PHILADELPHIA
BRIGNOLA, MD, MICHAEL P	PHILADELPHIA
BRILL, MD, DAVID R	MONTOUR
BRILL, MD, FRANCIS W	LACKAWANNA
BRILL, MD, JOSEPH M	DELAWARE
BRILL, MD, LESSA A	UNION
BRILLMAN, MD, DAVID A	ALLEGHENY
BRILLMAN, MD, JON	ALLEGHENY
BRINKMEYER, DO, SCOTT D	ALLEGHENY
BRISINI, MD, PATRICK D	CAMBRIA
BRISKIN, MD, JONATHAN A	DELAWARE
BRISTOWE, KEVIN D	STUDENT
BRITTON, MD, L LYNNE	DAUPHIN
BRIZUELA, DO, FELIX	WESTMORELAND
BRIZUELA, MD, HERNAN R	PHILADELPHIA
BRNDJAR, DO, JON E	LEHIGH
BROAD, MD, LOUIS T	PHILADELPHIA
BROCK, MD, CHARLENE M	PHILADELPHIA
BROCK, MD, RICHARD R	DAUPHIN
BROCKMAN, MD, RONALD J	MONTGOMERY
BROCKMAN, MD, STANLEY K	PHILADELPHIA
BROCKMEYER, MD, THOMAS F	ALLEGHENY
BROCKMOLE, MD, DEAN M	DAUPHIN
BROCKMYER, MD, M LAWRENCE	ERIE
BROCOUM, MD, CONSTANTINE P	ALLEGHENY
BROD, MD, JENNIFER S	DELAWARE
BROD, MD, ROBERT C	DELAWARE
BROD, MD, ROY D	LANCASTER
BRODE, MD, SUSAN E	PHILADELPHIA
BRODER, MD, GEORGE J	PHILADELPHIA
BRODEUR, MD, GARRETT M	PHILADELPHIA
BRODMERKEL JR, MD, GEORGE J	ALLEGHENY
BRODOVSKY, MD, HARVEY S	PHILADELPHIA
BRODSKY, MD, ISADORE	PHILADELPHIA
BRODSKY, MD, JEFFREY T	PHILADELPHIA
BRODSKY, MD, ROBERT L	ALLEGHENY
BRODSKY, MD, STEVEN G	BEAVER
BRODY, MD, JEROME I	PHILADELPHIA
BRODY, MD, JULIA B	PHILADELPHIA
BRODY, MD, LEONARD A	PHILADELPHIA
BRODY, MD, MARION B	PHILADELPHIA
BRODY, MD, MICHAEL C	BEAVER
BRODZINA, LYNNE M	STUDENT
BROENNLE, MD, A MICHAEL	PHILADELPHIA
BROGAN, MD, EDMUND J	PHILADELPHIA
BROGAN, MD, LOUIS E	PHILADELPHIA
BROMBERG, MD, JONATHAN B	PHILADELPHIA
BROMMER, MD, OLIVER R	PHILADELPHIA
BRON, MD, KERRY A	ALLEGHENY
BRON, MD, KLAUS M	ALLEGHENY
BRONFMAN, MD, HOWARD J	DAUPHIN
BRONITSKY, MD, BARBARA G	YORK
BRONITSKY, MD, CARL N	DAUPHIN
BRONSTEIN, MD, HOWARD D	PHILADELPHIA
BRONSTEIN, MD, SEYMOUR B	LUZERNE
BROOCKER, DO, BERNHARD L	MONTGOMERY
BROOKS, BRIAN P	STUDENT
BROOKS, MD, DANIEL H	ALLEGHENY
BROOKS, DO, FRANK J	WASHINGTON
BROOKS, MD, GERALD M	CRAWFORD
BROOKS, MD, HARRY R	DAUPHIN
BROOKS, MD, JACK C	LAWRENCE
BROOKS, MD, JAMES L	GREENE
BROOKS, MD, JANE F	WAYNE/PIKE
BROOKS, DO, JOHN M	CLARION
BROOKS, MD, MICHAEL L	PHILADELPHIA
BROOKS, MD, ROBERT	PHILADELPHIA
BROOKS, MD, RONALD J	MONTGOMERY
BROOKS, SUSAN L	STUDENT
BROOKS, DO, TIMOTHY S	CLARION
BROOKS, TRACY L	STUDENT
BROOKS III, MD, JAMES L	ALLEGHENY
BROOKS JR, MD, CLINT E	DELAWARE
BROPHY, MD, DOW E	CUMBERLAND
BROSELOW, MD, DAVID D	PHILADELPHIA
BROSNAN, MD, WILLIAM J	PHILADELPHIA
BROSS, MD, JAMES E	MONTOUR
BROSTOFF, MD, LEON M	ALLEGHENY
BROSTOFF, MD, PHILIP	ALLEGHENY
BROTHERS, BONNIE L	STUDENT
BROTHERS, MD, PAMELA J	CUMBERLAND
BROTHERSON, MD, GARY T	ERIE
BROTMAN, MD, DAVID N	LANCASTER
BROTZMAN JR, DO, WAYNE J	NORTHAMPTON
BROUDO, MD, SAMUEL F	PHILADELPHIA
BROUDY, MD, ARNOLD S	ALLEGHENY
BROUGHER, MD, DAVID E	ALLEGHENY
BROUSSARD, MD, DELMA L	PHILADELPHIA
BROUSSARD, MD, ELSIE R	ALLEGHENY
BROUSSEAU, MD, DAVID A	PHILADELPHIA
BROWN, MD, A CRAIG	ERIE
BROWN, MD, ANDREW J	ALLEGHENY
BROWN, DO, AVROM S	PHILADELPHIA
BROWN, CAROLYN M	STUDENT
BROWN, MD, CHARLES R	ALLEGHENY
BROWN, MD, CHRISTOPHER L	LEHIGH
BROWN, MD, CLARK E	PHILADELPHIA
BROWN, MD, DANA K	ALLEGHENY
BROWN, MD, DENNIS P	WASHINGTON
BROWN, MD, DONALD C	WESTMORELAND
BROWN, MD, FREDERICK G	MONTOUR
BROWN, MD, GARY C	PHILADELPHIA
BROWN, MD, GEORGE L	MONTGOMERY
BROWN, MD, GREGORY P	FRANKLIN
BROWN, MD, H ZANE	LANCASTER
BROWN, MD, HAROLD E	MONTOUR
BROWN, MD, J OLIVER	PHILADELPHIA
BROWN, MD, JODI H	PHILADELPHIA
BROWN, MD, JOHN H	MERCER
BROWN, MD, JOHN L	CLINTON
BROWN, MD, JOHN M	NORTHAMPTON
BROWN, MD, JOY M	MONROE
BROWN, MD, KENNETH R	PHILADELPHIA
BROWN, MD, LAWRENCE W	PHILADELPHIA
BROWN, MD, LESLIE A	PHILADELPHIA
BROWN, MD, LINDA E	PHILADELPHIA
BROWN, LINDA L	STUDENT
BROWN, MD, MANUEL L	ALLEGHENY
BROWN, DO, MARION L	DELAWARE
BROWN, MD, MARK S	POTTER
BROWN, MD, MATTHEW G	MERCER
BROWN, MD, MELISSA M	PHILADELPHIA
BROWN, MD, MICHAEL D	UNION
BROWN, MD, MICHAEL E	YORK
BROWN, MD, MICHAEL T	BERKS
BROWN, MD, NANCY A	CUMBERLAND
BROWN, MD, NATHAN	CHESTER
BROWN, PAMELA L	STUDENT
BROWN, MD, PATTI J	BERKS
BROWN, MD, RALPH R	INDIANA
BROWN, MD, RICHARD J	LANCASTER
BROWN, MD, ROBERT B	ALLEGHENY
BROWN, MD, ROBERT E	LANCASTER
BROWN, MD, ROBERT L	LUZERNE
BROWN, MD, ROBERT R	ALLEGHENY
BROWN, MD, SUSAN J	BUCKS
BROWN, MD, TIMOTHY M	WESTMORELAND
BROWN, VALERIE I	STUDENT
BROWN, MD, VICTORIA A	LEBANON
BROWN, MD, WILLIAM E	MERCER
BROWN, MD, WILLIAM E	MONTGOMERY
BROWN, MD, WYNNE R E	ALLEGHENY
BROWN III, MD, WILLIAM J	CAMBRIA
BROWN JR, MD, JAMES T	ALLEGHENY
BROWN JR, MD, JOSEPH S	MIFFLIN/JUNIATA
BROWN JR, MD, LOUIS A	PHILADELPHIA
BROWN JR, MD, M EVANS	MONTGOMERY
BROWN JR, MD, WILLIAM C	BUCKS
BROWN V, MD, THOMAS W	BUCKS
BROWN-BIEBER, MD, DALE E	LEBANON
BROWNE, MD, BARBARA J	PHILADELPHIA
BROWNSTEIN, MD, BRUCE K	PHILADELPHIA
BROWNSTEIN, MD, PHILLIP K	PHILADELPHIA
BROZA, MD, DAVID J	DAUPHIN
BRUBAKER, MD, J KENNETH	LANCASTER
BRUBAKER, MD, JACOB H	LANCASTER
BRUBAKER, MD, PAUL E	LANCASTER
BRUCE, MD, WILLIAM B	UNION
BRUCKER, MD, ALEXANDER J	PHILADELPHIA
BRUCKER, MD, PAUL C	PHILADELPHIA
BRUNDAGE, DO, RANDALL G	LACKAWANNA
BRUNELLI, MD, WILLIAM J	CAMBRIA
BRUNETTI, DO, STEVEN J	MONTGOMERY
BRUNGO, MD, JAMES J	ALLEGHENY
BRUNGO, MD, JOHN A	ALLEGHENY
BRUNGO, MD, JOHN D	ALLEGHENY
BRUNN JR, MD, HENRY M	ALLEGHENY
BRUNNER, MD, DOUGLAS J	DELAWARE
BRUNNER, MD, RICHARD A	PHILADELPHIA
BRUNO, MD, CARMAN S	ALLEGHENY
BRUNO, MD, JORGE C	ALLEGHENY
BRUNO, MD, LEONARD A	PHILADELPHIA
BRUNO, MD, PAT J	NORTHMBRLAND
BRUNO, DO, RAYMOND	NORTHAMPTON

BRUNO, MD, STEPHEN C	ALLEGHENY
BRUNO JR, MD, JOSEPH N	LUZERNE
BRUNO SR, MD, JOSEPH N	LUZERNE
BRUNSKILL, MD, DENNIS E	ALLEGHENY
BRUNT, JOYCE K	STUDENT
BRUNT JR, MD, MANLY Y	PHILADELPHIA
BRUTICO, MD, ANTHONY C	LACKAWANNA
BRUTICO JR, MD, CARMEN A	LACKAWANNA
BRYAN, MD, FRANK S	CUMBERLAND
BRYAN, MD, THOMAS M	DAUPHIN
BRYAN JR, MD, JOHN S	BUCKS
BRYAN JR, MD, ROSS E	WARREN
BRYANSMITH, MD, DALE	PHILADELPHIA
BRYANT, DARREN P	STUDENT
BRYANT, DAVID S	STUDENT
BRYANT, MD, DAVID W	CUMBERLAND
BRYANT JR, MD, WINSTON M	PHILADELPHIA
BRYFOGLE, MD, JOHN W	PHILADELPHIA
BRYLAWSKI, MD, MICHAEL	PHILADELPHIA
BRYSON, MD, RICHARD L	LANCASTER
BRZEZINSKI, MD, SANDRA A	CAMBRIA
BRZOZOWSKI, MD, JAN F	ERIE
BRZOZOWSKI, MD, LAWRENCE A	BERKS
BSAT, MD, FADI A	ERIE
BU, MD, TAE-HYUNG	ERIE
BUB, MD, IVAN	BERKS
BUBENHEIM, MD, DANIEL M	ALLEGHENY
BUCAN, MD, MICHAEL	LUZERNE
BUCAR, MD, JOHN R	ALLEGHENY
BUCCI, MD, LORENZO A	WESTMORELAND
BUCCI JR, MD, FRANK A	LUZERNE
BUCCO, DO, MARIA C	DELAWARE
BUCH, MD, DAVID L	MONTGOMERY
BUCH, MD, RAYMOND S	LEHIGH
BUCH, MD, ROBERT R	LANCASTER
BUCH, MD, SANDHYA Y	BERKS
BUCH BARKER, MD, DIANE M	ALLEGHENY
BUCHANAN IV, MD, HARRY W	LEHIGH
BUCHDAHL, MD, ALICE J	ALLEGHENY
BUCHER, MD, ROBERT G	BUCKS
BUCHER JR, MD, ROBERT W	DAUPHIN
BUCHHEIT, MD, WILLIAM A	PHILADELPHIA
BUCHKO, MD, SHEILA N	ALLEGHENY
BUCHMAN, MD, ROBERT R	ALLEGHENY
BUCHSBAUM, MD, ROY	ALLEGHENY
BUCK, MD, ANN L	ALLEGHENY
BUCK, MD, DAVID S	ALLEGHENY
BUCK, MD, DONALD E	PHILADELPHIA
BUCK, MD, KEITH K	ARMSTRONG
BUCK, MD, RUDOLPH L	ALLEGHENY
BUCK, MD, RUTH E	MONTGOMERY
BUCKEY, MD, JOSEPH T	LUZERNE
BUCKINGHAM, MD, ROBERT B	ALLEGHENY
BUCKINGHAM, MD, ROBERT C	DAUPHIN
BUCKLEN, MD, KEITH R	LANCASTER
BUCKLER, MD, RICHARD A	BUCKS
BUCKLEW, MD, LAWRENCE A	ALLEGHENY
BUCKLEY, MD, MARINA	WAYNE/PIKE
BUCKLEY, MD, RICHARD E	WAYNE/PIKE
BUCKLEY, MD, ROLAND M	PHILADELPHIA
BUCKMAN, MD, SAMUEL T	LUZERNE
BUCKMIRE, MD, MICHAEL A	PHILADELPHIA
BUCKNER, MD, SCOTT C	ALLEGHENY
BUCKO JR, MD, MATTHEW I	MONTGOMERY
BUCKWALTER, MD, JEFFREY A	BUCKS
BUCKWALTER, MD, RICHARD A	MONTGOMERY
BUCS, MD, ROGER G	DAUPHIN
BUCU, MD, ELEANOR IRENE B	DAUPHIN
BUDD, MD, CATHERINE B	BUCKS
BUDD, MD, ROBERT M	BLAIR
BUDEIR, MD, MOHAMMED H	CHESTER
BUDIKE, MD, ALEXANDRA B	DELAWARE
BUDNIAK, SHARON L	STUDENT
BUDURA, MD, PAUL	NORTHAMPTON
BUDUSKY, DO, CHARLES K	WESTMORELAND
BUDWAY, MD, RAYE J	ALLEGHENY
BUENO, MD, MAZZINI	MCKEAN
BUERGER, MD, DANIEL E	ALLEGHENY
BUERGER, MD, DAVID G	ALLEGHENY
BUERGER JR, MD, GEORGE F	ALLEGHENY
BUERK, MD, MINERVA S	MONTGOMERY
BUETOW, MD, MICHAEL P	DAUPHIN
BUFALINO, MD, KEVIN T	PHILADELPHIA
BUFFONE, MD, DAVID A	JEFFERSON
BUHL, MD, KEITH J	PHILADELPHIA
BUI, MD, HIEN T	STUDENT
BUJANAUSKAS, MD, PAUL	PHILADELPHIA
BUKHARI, MD, KHATIJA N	PHILADELPHIA
BULATAO, MD, AGAPITO V	BERKS
BULGARELLI, DO, ROBERT J	DELAWARE
BULGER, MD, DONALD W	BLAIR
BULGER, JOHN B	STUDENT
BULGER, MD, RICHARD H	BLAIR
BULKLEY, MD, TIMOTHY H	ALLEGHENY
BULLARD JR, MD, RAY E	WESTMORELAND
BULLOCK, MD, BRIAN W	DELAWARE
BULOVA, MD, STEPHEN I	PHILADELPHIA
BULSECO, MD, PATRICIA J	ALLEGHENY
BULTHUIS, DEANNA B	STUDENT
BUMGARDNER, MD, JAMES L	BUCKS
BUNDY, MD, THOMAS W	FRANKLIN
BUNESE, MD, HORST J	PHILADELPHIA
BUNIN, MD, NANCY J	PHILADELPHIA
BUNKER, MD, MARK L	ALLEGHENY
BUNYA, MD, VATHANA O	PHILADELPHIA
BUNYA, MD, VICHAI	PHILADELPHIA
BUONO, LAWRENCE	STUDENT
BUONOCORE, MD, BONNITA K	MONTGOMERY
BURAK, MD, WILLIAM E	LUZERNE
BURCHMAN, MD, COREY A	YORK
BURD, LAWRENCE T	STUDENT
BURDEN, MD, SAMUEL S	MONTGOMERY
BURDZIAK, DO, DOROTHY A	PHILADELPHIA
BURES, MD, J CONRAD	WESTMORELAND
BURG, MD, FREDRIC D	PHILADELPHIA
BURGBACHER, MD, JAMES S	CAMBRIA
BURGER, MD, REGIS F	ALLEGHENY
BURGER, MD, THEODORE P	NORTHAMPTON
BURGESS, MD, DONALD R	ALLEGHENY
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BURICK, MD, SHEILA M	VENANGO
BURKE, MD, BERNARD S	CHESTER
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BURKET, MD, RAMON C	BLAIR
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BURLAND, MD, J ALEXIS	PHILADELPHIA
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BURROUGHS, MD, BETH A	PHILADELPHIA
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BURSTEIN, MD, FRANK	PHILADELPHIA
BURSTEIN, MD, STUART S	ALLEGHENY
BURSTEIN, MD, WILLIAM H	PHILADELPHIA
BURTON, DO, PAUL D	INDIANA
BURTZO, DAVID M	STUDENT
BUSCH, MD, MICHAEL F	LEHIGH
BUSCHI, MD, MARIE	DAUPHIN
BUSECK, MD, MARK S	ERIE
BUSH, MD, BRUCE A	INDIANA
BUSH, MD, DAVID C	MONTOUR
BUSH, MD, HERMAN	BEAVER
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BUSH, MD, STEPHEN T	CAMBRIA
BUSH, MD, TODD A	VENANGO
BUSHKOFF, MD, STANLEY H	ALLEGHENY
BUSHMAN, MD, KARL E	ALLEGHENY
BUSHWICK, MD, BRUCE M	YORK
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BUSIS, MD, SIDNEY N	ALLEGHENY
BUSLER JR, MD, VERNE M	YORK
BUTANI, RAJ C	STUDENT
BUTCHER, MD, JULIE A	ALLEGHENY
BUTCHKO, MD, ANDREW W	MERCER
BUTELA, SHAWN R	STUDENT
BUTERA, MD, VINCENT	YORK
BUTERBAUGH, MD, GLENN A	ALLEGHENY
BUTKIEWICZ, MD, BERNARD L	LYCOMING
BUTLER, MD, ANNE K	TIOGA
BUTLER, MD, BRENDA J	PHILADELPHIA
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BUTLER, MD, CHRISTOPHER L	ALLEGHENY
BUTLER, MD, IVAN L	YORK
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BUTSON, MD, HARRY E	PHILADELPHIA
BUTT, MD, HAMEED A	LUZERNE
BUTT, MD, TAYYAB T	LUZERNE
BUTT JR, MD, FRANK H	WARREN
BUTTER, MD, DESIREE B	STUDENT
BUTTERFIELD, MD, SPENCER L	ALLEGHENY
BUTTERWICK, LAURA A	STUDENT
BUTTERWORTH, MD, THOMAS	BERKS
BUXTON JR, MD, DONALD R	DAUPHIN
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BUZAS, MD, JEROME W	BERKS
BUZBY, MD, FRANKLIN S	PHILADELPHIA
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BYBEL, MD, NICHOLAS	BERKS
BYER, MD, HAROLD H	BUCKS
BYERS, MD, JAMES F	ALLEGHENY
BYERS, MD, JOHN A	ALLEGHENY
BYERS, MD, KARIN E	PHILADELPHIA
BYERS, MD, ROBERT O	ERIE
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BYRON, MD, THOMAS W	LUZERNE

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CALEGA, MD, VIRGINIA C	DAUPHIN
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CAMITTA, MD, FRANCINE D	YORK
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CAMPANA, MD, JOSEPH F	LYCOMING
CAMPANA, MD, LOUIS F	LYCOMING
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CAMPANELLA, MD, STEPHEN D	ALLEGHENY
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CAMPBELL, MD, DAMALI M	STUDENT
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CAMPBELL, MD, DAVID R	COLUMBIA
CAMPBELL, ELIZABETH A	STUDENT
CAMPBELL, FAYE S	STUDENT
CAMPBELL, MD, JEFFREY W	ALLEGHENY
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CAMPBELL, MD, ROBERT E	PHILADELPHIA
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CAMPBELL, MD, SEAN C	YORK
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CAMPBELL, DO, THOMAS M	LUZERNE
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CAMPBELL, MD, WILLIAM L	ALLEGHENY
CAMPBELL II, JOHN T	STUDENT
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CAMPSEY, MD, D MICHAEL	STUDENT
CANALS, MD, JOAQUIN	MONTGOMERY
CANCELMO, MD, RICHARD P	MONTGOMERY
CANCINO, MD, JOSEFINA L S	ALLEGHENY
CANDAL, MD, MARIO A	LEHIGH
CANDELARIA, MD, JOSEFINA M	ALLEGHENY
CANDER, MD, LEON	PHILADELPHIA
CANDIA, MD, ANDREA J	BUCKS
CANDOW, DAVID L	STUDENT
CANE, MD, MARTIN	PHILADELPHIA
CANFIELD, MD, PATRICIA H	ALLEGHENY
CANINO, MD, CHRISTOPHER W	PHILADELPHIA
CANLAS, MD, JOLLY B	NORTHAMPTON
CANN, MD, TIMOTHY S	MONTGOMERY
CANN III, MD, THOMAS W	YORK
CANNER, MD, GARY C	BERKS
CANNING, MD, DOUGLAS A	PHILADELPHIA
CANNON, MD, CHRISTOPHER S	LEBANON
CANNON, MD, EDWARD J	PHILADELPHIA
CANO, MD, ELMER R	ALLEGHENY
CANOSE, MD, JEFFREY L	ALLEGHENY
CANOVA, MD, ANDRES E	PHILADELPHIA
CANTEES, MD, KIMBERLY K	ALLEGHENY
CANTERNA, MD, ANTHONY C	WASHINGTON
CANTOR, MD, CHARLES R	PHILADELPHIA
CAOILI, MD, ELAINE M	PHILADELPHIA
CAPLAN, MD, AARON	LAWRENCE
CAPLAN, MD, BERNARD	PHILADELPHIA
CAPLAN, MD, GARY E	CAMBRIA
CAPLAN, MD, JOHN L	PHILADELPHIA
CAPLAN, MD, MILTON L	LAWRENCE
CAPLAN, MD, MURRAY S	PHILADELPHIA
CAPLAN, MD, PAUL S	ALLEGHENY
CAPOBIANCO, MD, FRANK M	NORTHAMPTON
CAPONE, MD, GAETANO J	PHILADELPHIA
CAPONE, MD, RALPH A	WESTMORELAND
CAPONE JR, MD, RAYMOND A	ALLEGHENY
CAPPA, MD, ROBERT J	BERKS
CAPPIELLO, MD, JUSTIN L	LANCASTER
CAPPIELLO, MD, WILLIAM A	BUCKS
CAPPOLA JR, MD, MICHAEL T	PHILADELPHIA
CAPPUCCIO, MD, MATTHEW S	PHILADELPHIA
CAPRARO, MD, PHILIPPE A	NORTHAMPTON
CAPRIOLO, MD, MARK J	MONTOUR
CAPUTO, MD, LARRY A	PHILADELPHIA
CAPUZZI, MD, DAVID M	PHILADELPHIA
CARABALLO, RICARDO	STUDENT
CARABASI, MD, RALPH A	PHILADELPHIA
CARABASI III, MD, R ANTHONY	PHILADELPHIA
CARABELLI, MD, RONALD J	PHILADELPHIA
CARABELLO, MD, CHARLES A	BERKS
CARAMANNA, MD, JAMES F	WESTMORELAND
CARANDANG-PANIS, MD, NORMA H	PHILADELPHIA
CARAPELLA, MD, JOHN D	LEHIGH
CARAZOLA, MD, JOSEPH H	WASHINGTON
CARBAUGH, MD, HOWARD L	LEHIGH
CARBO, DO, ANTHONY P	DELAWARE
CARBONE, MD, GARY M	CARBON
CARBONI, MD, VINCENT A	LUZERNE
CARDAKLI, MD, UFUK F	BLAIR
CARDAMONE, MD, RALPH A	ALLEGHENY
CARDAMONE, MD, S JOSEPH	PHILADELPHIA
CARDELL, MD, ANTHONY F	DAUPHIN
CARDELLINO, MD, THOMAS J	CAMBRIA
CARDENAS, MD, FLORENCIO P	FAYETTE
CARDENAS, MICHAEL E	STUDENT
CARDIN, MD, ANDREW J	PHILADELPHIA
CARDINAL, MD, MARK S	LANCASTER
CARDINALE, DO, JOSEPH P	DAUPHIN
CARDONE, MD, ANITA L	ALLEGHENY
CARDONE, MD, JOHN C	ALLEGHENY
CARDWELL, MD, ROBERT J	LYCOMING
CAREL, MD, WARREN D	PHILADELPHIA
CARELLA, MD, RICHARD J	MONTGOMERY
CARETTI, MD, J WILLIAM	WESTMORELAND
CAREY, MD, EDWARD J	LUZERNE
CAREY, MD, EVA S	ALLEGHENY
CAREY, MD, JOHN L	LUZERNE
CAREY, MD, JOHN T	BEAVER
CAREY, MD, KEVIN V	BRADFORD
CAREY, DO, PATRICK J	LYCOMING
CAREY, MD, PHILIP D	CUMBERLAND
CAREY, MD, WILLIAM B	PHILADELPHIA
CARHART, MD, JUDY A	DAUPHIN
CARIM, MD, HYDER M	BERKS
CARIM, MD, MOIZ M	BERKS
CARINI, MD, JOHN F	LANCASTER
CARINO, MD, MARIEL G	LACKAWANNA
CARL, MD, GARY H	ALLEGHENY
CARLETON, MD, MARTA J	MONTOUR
CARLIN, MD, ELWIN S	MONTGOMERY

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CARLINI, MD, CHARLES J	ALLEGHENY
CARLONE, MD, DEBORAH S	PHILADELPHIA
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CARLSON, MD, KENNETH E	BEAVER
CARLSON, MD, ROBERT E	MONTGOMERY
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CARLUCCI, MD, RONALD J	PHILADELPHIA
CARMEN, MD, THOMAS F	ALLEGHENY
CARMONA, MD, ALDO	MONROE
CARNABUCI, MD, GUY J	PHILADELPHIA
CARNAVIL, DO, BRIAN D	MONTGOMERY
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CARNEY, MD, MARK E	PHILADELPHIA
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CARNICELLI, DO, GLENN L	ALLEGHENY
CARNIVALE, MD, SCOTT P	ALLEGHENY
CARO, MD, JOSE F	PHILADELPHIA
CAROE, MD, ALAN E	YORK
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CARP, MD, LEON M	PHILADELPHIA
CARP, MD, MASON J	DAUPHIN
CARPATHIOS, MD, MICHAEL P	ALLEGHENY
CARPENTER, MD, CATHY P	YORK
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CARR, MD, JAMES V	ALLEGHENY
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CARRANZA, MD, FREDERICK L	ALLEGHENY
CARRATO, MD, ANTHONY M	DELAWARE
CARRAU, MD, RICARDO L	ALLEGHENY
CARRELL, MD, ROBERT L	ALLEGHENY
CARREON, MD, ADRIAN W E	PHILADELPHIA
CARRIER, MD, WILLIAM W	YORK
CARROLL, DO, EDMUND T	BUCKS
CARROLL, MD, FRED	PHILADELPHIA
CARROLL, MD, LAURENCE E	LANCASTER
CARROLL, MD, NANCY E	ALLEGHENY
CARROLL, MD, ROBERT J	ALLEGHENY
CARROLL, MD, ROBERT T	PHILADELPHIA
CARROLL, MD, STANTON F	PHILADELPHIA
CARROLL, MD, WILLIAM L	DELAWARE
CARROZZA, MD, HARRY D	PHILADELPHIA
CARRUTHERS, MD, RALPH B	LANCASTER
CARSON, MD, CHARLES P	DELAWARE
CARSON, MD, DONALD G	ALLEGHENY
CARSON, MD, GREGORY B	MONTGOMERY
CARSON, MD, JAMES H	LANCASTER
CARSON, MD, JOHN S	MONTGOMERY
CARSON, MD, PAUL A	ALLEGHENY
CARSON, MD, TERESA C	MONTGOMERY
CARSON III, MD, JOHN N	YORK
CARTER, MD, CRAIG S	PHILADELPHIA
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CARTER, MD, DONALD L	WESTMORELAND
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CARTER, MD, JOHN A	BEAVER
CARTER, MD, JOSEPH H	ERIE
CARTER, MD, MICHELE	DELAWARE
CARTER, MD, RICARDO T D D	MIFFLIN/JUNIATA
CARTER, MD, THOMAS L	HUNTINGDON
CARTER JR, MD, JOSEPH H	YORK
CARTWRIGHT, MD, SCOTT R	VENANGO
CARTY JR, MD, JAMES B	MONTGOMERY
CARUANA, MD, BRUCE J	BERKS
CARUGATI, MD, RICHARD K	BEAVER
CARUSO, MD, JOHN W	PHILADELPHIA
CARUSO, DO, JUNE M	DELAWARE
CARVAJAL, MD, ROBERTO T	BUCKS
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CASAL, MD, ROLANDO A	DAUPHIN
CASALE, MD, LAWRENCE F	CAMBRIA
CASALE, MD, LOUIS J	BUCKS
CASALE, MD, PAUL N	LANCASTER
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CASALE, DO, TONI SAN MARIA	CUMBERLAND
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CASCIOTTI, DO, MICHAEL S	DAUPHIN
CASDORPH, MICHAEL L	STUDENT
CASE JR, MD, WARREN G	PHILADELPHIA
CASELLA, MD, ROBERT R	CAMBRIA
CASELLA, MD, SALVATORE R	MONTGOMERY
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CASEY, MD, JOHN D	PHILADELPHIA
CASEY, MD, KEVIN	PHILADELPHIA
CASEY, MD, MICHAEL P	ALLEGHENY
CASEY, MD, ROSEMARY D	PHILADELPHIA
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CASHER, MD, DANIELLE	PHILADELPHIA
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CASS, MD, STEPHEN P	ALLEGHENY
CASSEL, MD, FRANKLIN K	LANCASTER
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CASSELBERRY, MD, E JOSEPHINE	NORTHAMPTON
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CASTELLON-VOGEL, MD, CARLOS H	CAMBRIA
CASTIGLIONE, MD, ANGELO	ALLEGHENY
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CAVAN, MD, ALBINA B	LUZERNE
CAVAN, MD, JOHN F	LUZERNE
CAVANAUGH, MICHELLE L	STUDENT
CAVAROCCHI, MD, NICHOLAS C	PHILADELPHIA
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CELIO, MD, LEE A	PHILADELPHIA
CELKO, MD, DAVID A	ALLEGHENY
CELLINI, MD, L LUKE	DELAWARE
CENEDELLA, MD, STEPHEN C	VENANGO
CERA JR, MD, PETER J	MONTOUR
CERCIELLO, MD, MARK J	LEHIGH
CERCONE, DO, DAVID J	ALLEGHENY
CERCONE, MD, RONALD G	ALLEGHENY
CERMAK, MD, MARY BETH	ERIE
CERNE, MD, ANDREW J	WESTMORELAND
CERRI, MD, HUGO J M	ALLEGHENY
CERTA, MD, KENNETH M	PHILADELPHIA
CERTO, MD, LOUIS M	ALLEGHENY
CERTO, MD, SALVATORE A	ALLEGHENY
CERUL, MD, MAURICE S	ALLEGHENY
CERVONE, MD, PAUL N	WASHINGTON
CESANEK, MD, JOSEPH E	LUZERNE
CESARE, MD, JOSEPH G	LACKAWANNA
CESCON, MD, TERRENCE P	BERKS
CESSNA, MD, GERALD H	ALLEGHENY
CESSNA, WAYNE G	STUDENT
CESTELLO, MD, ROBERT J	ALLEGHENY
CEVALLOS, MD, EDUARDO A	BUCKS
CHABRA, MD, MOHAN L	ALLEGHENY
CHABY, DO, JEFFREY H	LANCASTER
CHADAGA, MD, P C S	DELAWARE
CHADDAH, MD, ASHOK	INDIANA
CHADWICK, MD, HAROLD H	BRADFORD
CHAFFEE, MD, JOHN S	ERIE
CHAFFEE, DO, REBECCA K	ERIE
CHAHIN, MD, JUAN J	WESTMORELAND
CHAI, MD, CHIU L	BUCKS
CHAI, MD, MIN S	LACKAWANNA
CHAI, MD, SUNGJI	LEHIGH
CHAIT, MD, ARNOLD	PHILADELPHIA
CHAKRAPANI, MD, RAJA M	ALLEGHENY
CHALAL, MD, GERALD S	PHILADELPHIA
CHALAL, MD, KENNETH	PHILADELPHIA
CHALFANT, MD, JOHN C	FAYETTE
CHALFANT, MD, RICHARD S	ALLEGHENY
CHALLENER, MD, KENNETH R	CRAWFORD
CHAMBERLIN, MD, MELISSA T	PHILADELPHIA
CHAMBERS, MD, CHRISTOPHER V	PHILADELPHIA
CHAMBERS, JENNIFER A	STUDENT
CHAMOVITZ, MD, BRUCE N	BEAVER
CHAMOVITZ, MD, JEROME	ALLEGHENY
CHAMOVITZ, MD, ROBERT	ALLEGHENY
CHAN, MD, ANNE K	PHILADELPHIA
CHAN, MD, DANIEL M	FRANKLIN
CHAN, MD, IAN	NORTHAMPTON
CHAN, SIDNEY	STUDENT
CHANCE, MD, PHILLIP F	PHILADELPHIA
CHANDLER, MD, BRUCE R	MERCER
CHANDRA, MD, DINESH N	WESTMORELAND
CHANDRA, MD, PRASANTA C	PHILADELPHIA
CHANDRA, MD, SEETHALAKSHMI	ALLEGHENY
CHANDRAN, MD, GIRIJA	CAMBRIA
CHANDRASEKARAN, MD, RAMAMURTI	ALLEGHENY
CHANDRASEKARAN, MD, SANNASIE	WESTMORELAND
CHANG, MD, ALEXANDER C S	ALLEGHENY
CHANG, MD, CHARLES H	WESTMORELAND
CHANG, MD, CHRIS C	LEHIGH
CHANG, MD, CHUN S	LUZERNE
CHANG, MD, CLAYTON W	MONTGOMERY
CHANG, MD, DUCK-KYU	CUMBERLAND
CHANG, MD, EDWARD J	ALLEGHENY
CHANG, MD, EUGENE Y	PHILADELPHIA
CHANG, HELEN C	STUDENT
CHANG, MD, IN-HO	LEHIGH
CHANG, MD, KUN T	PHILADELPHIA
CHANG, MD, MONA P	LYCOMING
CHANG, RICHARD S	STUDENT
CHANG, SHIRLEY S	STUDENT
CHANG, SYLVIA S	STUDENT
CHANG, MD, TONY CHI-KUE	NORTHAMPTON
CHANG, WON S	STUDENT
CHANGCO, MD, ALVARO N	WASHINGTON
CHANNAPATI, MD, THIPPESWAMY	BUTLER
CHANNICK, MD, STEVEN A	MONTGOMERY
CHAO, MD, WEN	PHILADELPHIA
CHAPA, MD, SUKUMAR M	CLARION
CHAPIS, MD, GREGORY J	PHILADELPHIA
CHAPIS, MD, NICHOLAS J	MONTGOMERY
CHAPLIN, MD, STANLEY S	PHILADELPHIA
CHAPMAN, MD, ALBERT L	DAUPHIN
CHAPMAN, DO, ANDREW E	PHILADELPHIA
CHAPMAN, MD, CHRISTOPHER N	NORTHAMPTON
CHAPMAN, MD, JOSEPH L	PHILADELPHIA
CHAPMAN, MD, WILLIAM L	ALLEGHENY
CHAPMAN-ROLLE, MD, LORETTA D	PHILADELPHIA
CHAPPANO, MD, PAUL J	ALLEGHENY
CHAPPELL, MD, JAMES C	PHILADELPHIA
CHARABATI, MD, JAY	LUZERNE
CHAREPOO, MD, KHASHAIAR	WARREN
CHARLES, MD, KRISTINE K	ALLEGHENY
CHARLES, MD, ROBERT S	MONTGOMERY
CHARLES-MARCEL, MD, ZENO L	BERKS
CHARLESWORTH, MD, ERNEST E	FRANKLIN
CHARLEY, MD, JOHN A	ALLEGHENY
CHARLEY, MD, MICHAEL R	ALLEGHENY
CHARLSON, MD, MURRAY T	ALLEGHENY
CHARNEY, MD, ALAN N	WAYNE/PIKE
CHARNEY, MD, RICHARD H	BUCKS
CHARRON, MD, MARTIN	ALLEGHENY
CHASE, MD, HAROLD F	PHILADELPHIA
CHASE, MD, JEFFREY S	MONTGOMERY
CHASE, MD, WILLIAM D	CENTRE
CHASTENEY III, MD, EDWARD A	PHILADELPHIA
CHASTKA, MD, EDWARD A	BERKS
CHAT, MD, EMANUEL	PHILADELPHIA
CHATHA, MD, IFTIKHAR A	MERCER
CHATREE-DUANGNET, MD, CHAD	LAWRENCE
CHATTA, MD, FOZIA A	FAYETTE
CHATTAH, MD, LEON	NORTHAMPTON
CHATTERJEE, MADHUMITA	STUDENT
CHATTERJEE, MD, MINAKSHI	DELAWARE
CHATWIN, AMBER L	STUDENT
CHATZINOFF, MD, MARTIN	MONTGOMERY
CHAUDHARI, MD, SUNITA N	ALLEGHENY
CHAUDHARY, MD, SAFDAR I	ALLEGHENY
CHAUDHRI, MD, MUNAWAR S	DELAWARE
CHAUDHRY, HAROON W	STUDENT
CHAUDHRY, MD, MEHBOOB K	ALLEGHENY
CHAUDHRY, MD, MOHAMMAD A	MONROE
CHAUDHRY, MD, RAHAT M	ALLEGHENY
CHAUHAN, MD, AMBARAM V	ALLEGHENY
CHAVLA, MD, NAEEM T	DAUPHIN
CHAWLA, MD, HARISH C	BUCKS
CHAWLUK, MD, JOHN B	SCHUYLKILL
CHAYAPRUKS, MD, PRAYUN	GREENE
CHECCHIO, MD, LEONARD M	MONTGOMERY
CHECK, MD, JEROME H	MONTGOMERY
CHEEVER, MD, FRANCIS S	ALLEGHENY
CHEIKIN, MD, MICHAEL I	MONTGOMERY
CHELIUS, MD, ALAN B	BERKS
CHEN, MD, ALEX S J	ALLEGHENY
CHEN, MD, ANNE	ALLEGHENY
CHEN, MD, CHIJEN	DELAWARE
CHEN, MD, EDWARD C H	NORTHAMPTON
CHEN, MD, HENRY Y	VENANGO
CHEN, PETER J	STUDENT
CHEN, MD, ROBERT F	ALLEGHENY
CHEN, MD, TAI-WEN	ALLEGHENY
CHEN, MD, WEI-FAN	PHILADELPHIA
CHEN, MD, XIAOLI	PHILADELPHIA
CHENEY, MD, MARYALICE	PHILADELPHIA
CHENEY, MD, RICHARD T	LANCASTER
CHENG, MD, CHUN-PIN	ALLEGHENY
CHENG, MD, CYNTHIA	STUDENT
CHENG, MD, DAVID T	ALLEGHENY
CHENG, MD, HARVEY S	LEHIGH
CHENG, MD, KENNETH P	ALLEGHENY
CHENG, MD, LAWRENCE C	LEHIGH
CHENG, MD, RU FONG J	PHILADELPHIA
CHENGAPPA, MD, PALECANDA P	ALLEGHENY
CHENSEE, MD, JASPER G	BERKS
CHEPONIS, MD, GEORGE B	ALLEGHENY
CHERIAN, MD, GEORGE R	JEFFERSON
CHERNEGA-SPIEKERMANN, MD, JOY	PHILADELPHIA
CHERNEY, MD, PAUL J	PHILADELPHIA
CHERNOFF, MD, ARTHUR	PHILADELPHIA
CHERNOFF, MD, BENJAMIN	PHILADELPHIA
CHERNOFF, MD, ROBERT W	DELAWARE
CHERNOFSKY, MD, MICHAEL A	LEHIGH
CHERRY, MD, KENNETH L	CENTRE
CHERRY, MD, LOUIS J	JEFFERSON
CHERRY, MD, MELANIE M	CENTRE
CHERRY, MD, ROBERT J	JEFFERSON
CHERRY, MD, SCOTT M	YORK
CHERRY, MD, STEVEN B	CUMBERLAND
CHERUP, MD, E DAVID	ALLEGHENY
CHERUP, MD, LORI L	ALLEGHENY
CHESEK, MD, LORRAINE M	ALLEGHENY
CHESEN, MD, DAVID	PHILADELPHIA
CHESIN, MD, CAROLE M	ALLEGHENY
CHESNICK, MD, STEVEN R	MONTGOMERY
CHESS, MD, DANIEL J	ALLEGHENY
CHESTER, MD, JANIS G	PHILADELPHIA
CHETLIN, MD, STUART H	ALLEGHENY
CHETT, MD, NICHOLAS J	BERKS
CHEYNEY II, MD, JAMES B	MONTGOMERY
CHHABRIA, MD, MAHESH D	MONROE
CHI, MD, NUNGJA	PHILADELPHIA
CHIANG, CARY H	STUDENT
CHIAPELLA, MD, CARLA D	NORTHAMPTON
CHIARAMONTE, MD, CATHE A	PHILADELPHIA
CHIARAMONTE III, MD, ANTHONY	PHILADELPHIA
CHIAVACCI, MD, ANTHONY L	LACKAWANNA
CHIAVACCI, MD, EUGENE J	LACKAWANNA
CHICKLO, MD, JAMES M	FRANKLIN
CHICO, MD, LAURO V	ALLEGHENY
CHIESA, MD, NICOLETTE E	ALLEGHENY
CHIKARMANE, MD, AJIT M	LUZERNE
CHIKARMANE, MD, KALPANA A	LUZERNE
CHILDRESS, MD, CYNTHIA H	PHILADELPHIA
CHILDS, MD, MARION C	CHESTER
CHILDS, MD, ROBERT W	LUZERNE
CHILDS, MD, USHA M	PHILADELPHIA
CHILDS III, MD, JOHN N	PHILADELPHIA
CHILES, PATRICK J	STUDENT
CHIN, MD, ALVIN J	PHILADELPHIA
CHIN, MD, BYOUNG KWON	BUCKS
CHIN, KATHLEEN L	STUDENT
CHINEA, MD, CARMEN	CAMBRIA
CHINITZ, MD, JOEL L	PHILADELPHIA
CHINSKY, MD, KENNETH D	ERIE
CHINTA, MD, JYOTHI	MONTGOMERY
CHIRIELEISON, MD, ROCCO F	BERKS
CHISHOLM, PATRICIA A	STUDENT
CHISMER, MD, MICHAEL E	ALLEGHENY
CHISUM, MD, MELVIN J	PHILADELPHIA
CHITALE, MD, VIDYADHAR S	DELAWARE
CHITTIPROLU, MD, JAGAN R	DELAWARE
CHIU, DAVID M	STUDENT
CHMIELEWSKI, MD, PAUL W	PHILADELPHIA
CHMIELEWSKI, MD, ROBERT E	PHILADELPHIA
CHO, MD, DOO W	BLAIR
CHO, MD, JAY J	DAUPHIN
CHO, MD, JONG S	FAYETTE
CHO, MD, YONG D	WASHINGTON
CHOBY, MD, JOHN J	BUCKS
CHODAKEWITZ, MD, JEFFREY A	PHILADELPHIA
CHODROFF, MD, CHARLES H	YORK
CHOGICH, MD, JOHN C	DELAWARE
CHOI, MD, EDWARD W	LUZERNE
CHOI, MD, JOHN K	PHILADELPHIA
CHOI, MD, JONG J	WESTMORELAND
CHOI, MD, KWANG Y	CRAWFORD
CHOI, MD, SEAN H	ALLEGHENY
CHOI, MD, SUSANNA S	ALLEGHENY
CHOI, MD, TOHSHIK	MONTGOMERY
CHOLAPRANEE, MD, REWAT	ALLEGHENY
CHOLHAN, MD, R C	LUZERNE
CHOMSKY, MD, DAVID E	PHILADELPHIA
CHOONG, MD, SHUNG S	SCHUYLKILL
CHOPRA, ANUJ K	STUDENT
CHOPRA, MD, RAJ P	COLUMBIA
CHOPRA, VIKAS	STUDENT
CHORAZY, MD, ANNA J	ALLEGHENY
CHORAZY, MD, ZDZISLAW J	ERIE
CHORY, MD, EDWARD T	LANCASTER
CHOTINER, MD, BENNETT	DAUPHIN
CHOUGH, MD, ANDREW C B	ALLEGHENY
CHOVANES, MD, GEORGE I	LEHIGH
CHOW, SERENA A	STUDENT
CHOWDARY, MD, RAJ P	LEHIGH
CHOWDHRY, MD, ZAFAR I	ARMSTRONG
CHOWDHURY, MD, A RAB	BERKS
CHREKY, MD, EMILE H	ALLEGHENY
CHRIST, MD, NICHOLAS J	BERKS
CHRIST, MD, PETER J	BERKS
CHRISTENSEN, MD, DAVID W	BERKS
CHRISTENSEN, DO, G CHRIS	MONTGOMERY
CHRISTESEN, MD, STEVEN D	PHILADELPHIA
CHRISTIAN, MD, CINDY W	PHILADELPHIA
CHRISTIAN, MD, COLLEEN J	PHILADELPHIA
CHRISTIAN, MD, DEAN A	COLUMBIA
CHRISTIAN, MD, EUGENE P	WASHINGTON
CHRISTIAN, MD, HORACE D	ALLEGHENY

CHRISTIANSEN, MD, KJELL H	MONTGOMERY
CHRISTIANSON, MD, ALAN D	WESTMORELAND
CHRISTIDES, MD, STEPHAN A	PHILADELPHIA
CHRISTIE, MD, KARL B	ALLEGHENY
CHRISTIE, DO, PETER N	DELAWARE
CHRISTIE, MD, THOMAS	CHESTER
CHRISTIE, MD, WILLIAM C	ALLEGHENY
CHRISTINE, DO, CRAIG R	LEHIGH
CHRISTMAN, MD, JAMES C	LEBANON
CHRISTOFORETTI, MD, RUSSELL J	WASHINGTON
CHRISTOPHERSON, MD, WAYNE A	ALLEGHENY
CHRISTY, MD, MICHAEL G	ALLEGHENY
CHRISTY, MD, PATRICK T	STUDENT
CHU, DO, ALEX	PHILADELPHIA
CHU, MD, ANN M	PHILADELPHIA
CHU, MD, DONALD	PHILADELPHIA
CHU, MD, ELSIE H	PHILADELPHIA
CHU, MD, JENNIFER	PHILADELPHIA
CHU, MD, KIMWAI	YORK
CHU, MD, WINSTON	ERIE
CHUA, MD, CHONG V	MONTGOMERY
CHUENSUMRAN, MD, ONGART	ALLEGHENY
CHUENSUMRAN, MD, RAJANI S	ALLEGHENY
CHUGHTAI, MD, ARSHAD I	ALLEGHENY
CHUGHTAI, MD, MUBASHAR S	ALLEGHENY
CHUKUMBA, BEATRICE C	STUDENT
CHUKWUEKE, MD, THEOPHILUS O	PHILADELPHIA
CHUN, MD, YOON-TAEK	MONROE
CHUNG, MD, C KUN	LACKAWANNA
CHUNG, MD, CHIN D	LAWRENCE
CHUNG, MD, CHIN-YONG	ERIE
CHUNG, D CHRISTOPHER	STUDENT
CHUNG, MD, EDWARD K	PHILADELPHIA
CHUNG, MD, ESTHER K	PHILADELPHIA
CHUNG, MD, HACK R	MONTGOMERY
CHUNG, MD, HI-YOUNG	LUZERNE
CHUNG, JUDITH H	STUDENT
CHUNG, MD, KI Y	ALLEGHENY
CHUNG, MD, KWANG H	ALLEGHENY
CHUNG, MD, WHAN S	PHILADELPHIA
CHUNG-HONET, MD, LINDA C	PHILADELPHIA
CHUNN, MD, LIVINGSTON	PHILADELPHIA
CHURCH, MD, JEFFREY S	YORK
CIACCI, MD, VINCENT W	CHESTER
CIAIO, MD, CAROLE-JAY	ALLEGHENY
CIAMBOTTI, MD, GARY F	ALLEGHENY
CIAMBOTTI, DO, JONATHAN M	STUDENT
CIANCIULLI, MD, FRANCIS D	DELAWARE
CIANFRANI, MD, PETER M	BUCKS
CIBIK, MD, LISA M	WASHINGTON
CICCARELLI, MD, CLEM A	YORK
CICCARELLI, MD, HAROLD E	ALLEGHENY
CICCARELLI, MD, LEE M	LYCOMING
CICCHINO, MD, FRANK E	ALLEGHENY
CICCONE, MD, PATRICK E	BUCKS
CICCONE II, MD, WILLIAM J	DAUPHIN
CICCOTELLI, MD, ALDO A	BUCKS
CICHELLI, MD, ANDREW V	PHILADELPHIA
CICHON, MD, PHILIP J	ALLEGHENY
CICUTO, DO, ROBERT A	MERCER
CIFOR, DO, SANDRA M	FRANKLIN
CIGANIC, MD, RATIMIR R	ALLEGHENY
CIGNETTI, MD, FRANKLIN E	ALLEGHENY
CINCALA, DO, ROBERT P	ALLEGHENY
CINCOTTA, DO, ANTHONY J	PHILADELPHIA
CINCOTTA, MD, JANET F	DAUPHIN
CINCOTTA, MD, JOSEPH A	DAUPHIN
CIOTOLA, MD, AUGUSTINE A	LUZERNE
CIOTOLA, MD, JOSEPH G	LUZERNE
CIOTOLA, MD, THOMAS J	LUZERNE
CIOTTI, DO, ANNETTE A	ALLEGHENY
CIPOLLA, MD, CHARLES F	LYCOMING
CIPPEL, MD, JOSEPH A	CUMBERLAND
CIRELLI, MD, MARIO G	PHILADELPHIA
CIRELLI, MD, ROSEMARY A	PHILADELPHIA
CIRELLY, DO, FRANCINE A	PHILADELPHIA
CIRIGLIANO, MD, DANIEL A	BUCKS
CIRILLO JR, MD, ROBERT L	STUDENT
CIROTTI, MD, JOSEPH J	MONTGOMERY
CITRO, MD, LAURENCE A	BERKS
CITRONE, MD, PETER J	ALLEGHENY
CITTI, MD, JOHN G	LUZERNE
CIVITARESE, MD, LOUIS R	ALLEGHENY
CLADER, MD, STANLEY C	MONTGOMERY
CLAIR, MD, DAVID L	LEHIGH
CLANCY, MD, MICHAEL	PHILADELPHIA
CLANCY JR, MD, ROBERT R	PHILADELPHIA
CLARE, MD, DAVID W	ALLEGHENY
CLARE, MD, HENRY E	DELAWARE
CLARK, MD, ANN K	WESTMORELAND
CLARK, MD, BERNARD J	PHILADELPHIA
CLARK, MD, FRANCIS J	MONTGOMERY
CLARK, MD, GRANT C	COLUMBIA
CLARK, MD, JAMES E	DELAWARE
CLARK, MD, JOSEPH M	LEBANON
CLARK, MD, KEVIN D	ALLEGHENY
CLARK, DO, KEVIN R	LANCASTER
CLARK, MD, LAWRENCE M	CLARION
CLARK, MD, LIANA R	PHILADELPHIA
CLARK, MD, LINDA J	CUMBERLAND
CLARK, MD, M DORCAS	INDIANA
CLARK, MD, MICHAEL L	BLAIR
CLARK, MD, NEIL R	LANCASTER
CLARK, MD, RICHARD E	ALLEGHENY
CLARK JR, MD, GORDON H	ERIE
CLARK JR, JERRY R	STUDENT
CLARKE, MD, CATHERINE F	MONTGOMERY
CLARKE, MD, CHARLES E	ALLEGHENY
CLARKE, DEBORAH A	STUDENT
CLARKE, MD, FRANKLYN R	BUCKS
CLARKE, MD, L JOHN	WAYNE/PIKE
CLARKE, MD, LEON E	PHILADELPHIA
CLARKE, MD, ROBERT H	ALLEGHENY
CLARY, MD, ANNE A	NORTHAMPTON
CLASSEN, MD, CAROLYN F	ADAMS
CLASSEN, MD, CHARLES H	MONTGOMERY
CLAUHS, MD, RONALD P	CHESTER
CLAUSS, MD, THOMAS F	LACKAWANNA
CLAVES, JENNIFER L	STUDENT
CLAWSON, DO, KEVIN R	ALLEGHENY
CLAY, MD, BETTIE W	CHESTER
CLAY, MD, STEPHEN N	DELAWARE
CLAYTON, DO, JOHN S	CHESTER
CLAYTON, MD, RICHARD J	CHESTER
CLAYTON, MD, THOMAS D	CHESTER
CLAYTON JR, MD, SAMUEL T	DAUPHIN
CLEARFIELD, MD, HARRIS R	PHILADELPHIA
CLEARFIELD, MD, RONALD J	WESTMORELAND
CLEARFIELD, DO, WILLIAM N	LUZERNE
CLEARY, DO, GERARD M	PHILADELPHIA
CLEAVER, MD, CLARENCE P	COLUMBIA
CLEAVER, MD, DOROTHY M	MONTGOMERY
CLEAVER, MD, E EUGENE	MONTGOMERY
CLELAN, MD, GEORGE M	LANCASTER
CLEMENS, MD, THOMAS M	LEBANON
CLEMENT, MD, GORDON S	MONTGOMERY
CLEMENT, MD, JOHN A	MONTOUR
CLEMENTS, MD, DAVID H	WESTMORELAND
CLEMENTS, MD, DAVID H	PHILADELPHIA
CLEMENTS, MD, JAMES K	WASHINGTON
CLEMENTS, MD, MICHAEL J	NORTHMBRLAND
CLEMENTS, MD, WILLIAM T	BERKS
CLEMENTS, MD, WILLIAM W	MONTGOMERY
CLERICO, MD, DEAN M	LUZERNE
CLEVENGER, MD, ROBERT W	ALLEGHENY
CLEVER, MD, JOHN E	ALLEGHENY
CLEWELL, MD, KAREN M	DAUPHIN
CLIFFORD, MD, GAIL L	DAUPHIN
CLIFTON, MD, PAMELA A	DAUPHIN
CLIMACO, MD, RAFAEL V	LUZERNE
CLINE, MD, CHARLES W	ALLEGHENY
CLIPP, MD, SAMUEL W	BUCKS
CLISTA, MD, BRIAN T	ALLEGHENY
CLOHERTY, MD, KERI M	PHILADELPHIA
CLOSE, MD, RICHARD A	BERKS
CLOSKEY, MD, GREGORY M	MONTGOMERY
CLOSSON, MD, EDWARD W	PHILADELPHIA
CLOUGH, MD, DOUGLAS F	ALLEGHENY
CLOUSE, MD, RICHARD M	BUTLER
CLYMAN, MD, BYRON	MONTGOMERY
CLYMER, MD, DAVID G	BERKS
CO, MD, DEBORAH JANE L	ALLEGHENY
CO, MARY DAWN T	STUDENT
COADY, JENNIFER A	STUDENT
COADY, MD, PAUL M	CHESTER
COAR, MD, GEORGE R	LUZERNE
COATES JR, MD, JOHN B	CHESTER
COBBINAH, MD, INGENUE F	ALLEGHENY
COBERT, MD, HOWARD S	PHILADELPHIA
COBETTO, MD, BERNARD H	WESTMORELAND
COBLENTZ, MD, ROBERT H	ALLEGHENY
COCCO, MD, ALEX M	MERCER
COCHRAN, MD, JAMES F	NORTHAMPTON
COCHRAN, MD, TERENCE A	LACKAWANNA
COCHRAN, MD, WILLIAM C	MONTGOMERY
COCHRAN, MD, WILLIAM J	MONTOUR
COCHRANE, MD, PETER J	NORTHAMPTON
CODARIO, MD, RONALD A	PHILADELPHIA
CODISPOTI, MD, JOSEPH R	PHILADELPHIA
COFFEY, MD, JAMES A	BERKS
COFFEY, MD, WILLIAM F	PHILADELPHIA
COFFIN, MD, SUSAN E	MONTGOMERY
COFFMAN, MD, KAOHLIN M	LYCOMING
COFFMAN, STEPHAN W	STUDENT
COGEN, MD, FREDERICK C	MONTGOMERY
COHAN, MD, HAL D	MONTGOMERY
COHEN, MD, ALAN R	PHILADELPHIA
COHEN, DO, ALICE L	LANCASTER
COHEN, DO, ANDREW J	LEHIGH
COHEN, MD, ARCHIBALD C	BUTLER
COHEN, MD, ARNOLD W	PHILADELPHIA
COHEN, MD, BERNARD I	ALLEGHENY
COHEN, MD, BRIAN E	DAUPHIN
COHEN, MD, BRUCE A	BERKS
COHEN, MD, CATHY S	ALLEGHENY
COHEN, MD, DANIEL J	BUCKS
COHEN, MD, DAVID A	PHILADELPHIA
COHEN, MD, DAVID E	MONTGOMERY
COHEN, MD, DAVID L	YORK
COHEN, MD, DONALD L	MERCER
COHEN, MD, ERWIN A	PHILADELPHIA
COHEN, MD, FREDRIC L	CHESTER
COHEN, MD, H EMMANUEL	PHILADELPHIA
COHEN, DO, HERMAN P	PHILADELPHIA
COHEN, MD, IRA J K	ALLEGHENY
COHEN, MD, IVAN S	MONTGOMERY
COHEN, MD, J STANLEY	PHILADELPHIA
COHEN, MD, JACOB J	PHILADELPHIA
COHEN, MD, JEFFREY H	ALLEGHENY
COHEN, MD, JEFFREY K	ALLEGHENY
COHEN, MD, JEFFREY S	STUDENT
COHEN, DO, JILL B	PHILADELPHIA
COHEN, MD, KENNETH D	PHILADELPHIA
COHEN, MD, LARRY K	ALLEGHENY
COHEN, DO, LAURIE A	LEHIGH
COHEN, MD, LEONARD M	ALLEGHENY
COHEN, MD, MARTIN A	BUCKS
COHEN, MD, MARTIN H	PHILADELPHIA
COHEN, MARY E	STUDENT
COHEN, MD, MERTON E	NORTHAMPTON
COHEN, MD, MEYER A	PHILADELPHIA
COHEN, MD, MICHAEL M	PHILADELPHIA
COHEN, MD, MILTON H	MIFFLIN/JUNIATA
COHEN, MD, MURRAY J	PHILADELPHIA
COHEN, MD, NORMAN F	ALLEGHENY
COHEN, MD, NORMAN N	PHILADELPHIA
COHEN, MD, PETER Z	ALLEGHENY
COHEN, MD, PINCHAS	PHILADELPHIA
COHEN, MD, RICHARD L	ALLEGHENY
COHEN, DO, ROBERT A	ALLEGHENY
COHEN, MD, ROBERT M	PHILADELPHIA
COHEN, MD, SAMUEL F	MONTGOMERY
COHEN, MD, SARLE H	PHILADELPHIA
COHEN, MD, SHERWOOD V	PHILADELPHIA
COHEN, MD, STANLEY	PHILADELPHIA
COHEN, MD, STANLEY N	PHILADELPHIA
COHEN, MD, THEODORE B	PHILADELPHIA
COHEN, MD, THOMAS	LUZERNE
COHEN, DO, WILLIAM L	DELAWARE
COHEN, MD, WILLIAM W	ERIE
COHLER, MD, ALAN	BUCKS
COHN, MD, BURTON H	DAUPHIN
COHN, MD, C HAROLD	BERKS
COHN, MD, EDWIN M	PHILADELPHIA
COHN, MD, HERBERT E	PHILADELPHIA
COHN, MD, JEFFREY B	PHILADELPHIA
COHN, MD, JOHN R	PHILADELPHIA
COHN, MD, RONALD E	PHILADELPHIA
COIL JR, MD, JAMES A	CAMBRIA
COLA, DO, CAROL D	MONTGOMERY
COLAIACOVO, MD, LYNN A	ALLEGHENY
COLANTONI, MD, WILLIAM	WASHINGTON
COLAO, DO, DOMINIC J	ALLEGHENY
COLASANTE, MD, ANTHONY D	NORTHAMPTON
COLATRELLA, MD, ANTHONY M	ALLEGHENY
COLAVINCENZO, MD, JOHN W	BEAVER
COLAVITA, PASQUALE A	STUDENT
COLBERG, MD, JAMES E	PHILADELPHIA
COLBURN JR, MD, HAROLD L	PHILADELPHIA
COLCHER, MD, IRVING S	MONTGOMERY
COLCHER, MD, ROBERT E	MONTGOMERY
COLDREN, MD, CAROL L	CHESTER
COLDREN, MD, ROBERT L	DAUPHIN
COLDREN, MD, SEAN C	LANCASTER
COLE, MD, DANIEL J	ALLEGHENY
COLE, MD, DENNIS G	ERIE
COLE, DO, DERHYMERE L	MERCER
COLE, MD, JACK E	NORTHAMPTON
COLE, MD, JAMES M	MONTOUR
COLE, MD, K NIKI	PHILADELPHIA
COLE, EXEC DIR, MD, RICHARD S	WESTMORELAND
COLE JR, MD, CHARLES L	UNION
COLEMAN, MD, DONALD K	NORTHAMPTON
COLEMAN, MD, ERNEST H	CENTRE
COLEMAN, KRISTIN H	STUDENT
COLEMAN, MD, MARTIN R	DELAWARE
COLEMAN, DO, MICHAEL H	BUTLER
COLEMAN, MD, THOMAS H	LACKAWANNA
COLEMAN JR, MD, ERNEST H	DAUPHIN
COLEMAN-BRACKEN, DO, BARBARA A	DELAWARE
COLETTA, MD, ANTHONY V	MONTGOMERY
COLETTA, MD, DANIEL J	BUCKS
COLL, DAVID A	STUDENT
COLL, MD, WILLIAM X	PHILADELPHIA
COLLAZO, MD, ERNESTO L	PHILADELPHIA
COLLEY, MD, ALFRED L	PHILADELPHIA
COLLIER, DAVID J	STUDENT
COLLIER, MD, JAMES T	ALLEGHENY
COLLIER, MD, PAUL E	ALLEGHENY
COLLIER, MD, THOMAS F	DAUPHIN
COLLIER JR, MD, ANDREW J	PHILADELPHIA
COLLINI, MD, FRANCIS J	LUZERNE
COLLINS, CARLA C	STUDENT
COLLINS, MD, DEIRDRE M	BUCKS
COLLINS, MD, FRANK J	YORK
COLLINS, MD, KENNETH P	CHESTER
COLLINS, MD, LAWRENCE A	ALLEGHENY
COLLINS, MD, LEONARD R	LYCOMING
COLLINS II, MD, J JOHN	LEHIGH
COLLINS JR, MD, RICHARD F	ALLEGHENY
COLLURA, MD, PAUL T	LANCASTER
COLMENAR, MD, ANTONIO B	PHILADELPHIA
COLODNY, MD, STEPHEN M	ALLEGHENY
COLOMBO, MD, JAMES L	DELAWARE
COLON-DELGADO, MD, RAFAEL I	LEHIGH
COLTMAN, MD, ARTHUR B	PHILADELPHIA
COLTON, MD, MARC D	PHILADELPHIA
COLVIN, MD, CAROL A	BEAVER
COMAS, MD, MICHAEL G	CAMBRIA
COMBS, MD, DOUGLAS V	NORTHAMPTON
COMBS, MD, WILLIAM G	PHILADELPHIA
COMER, MD, NATHAN L	PHILADELPHIA
COMESS, MD, RAYMOND R	BERKS
COMP, MD, SCOTT J	ERIE
COMSTOCK, MD, LLOYD K	ALLEGHENY
CONAHAN, MD, BERNARDIN Q	BUCKS
CONAHAN JR, MD, JOSEPH B	MONROE
CONAWAY, MD, BRUCE E	ALLEGHENY
CONCILUS, MD, FRANK	ALLEGHENY
CONCOOL, MD, BARRY M	BUCKS
CONDIT, MD, BRIAN E	ALLEGHENY
CONDON, MD, GARRY P	ALLEGHENY
CONDON, MD, ROBERT H	DELAWARE
CONDRON, MD, BRIAN P	LANCASTER
CONE, MD, ALEXANDER S	ALLEGHENY
CONE, MD, LIBBY	PHILADELPHIA
CONFER, MD, MICHELLE A	BLAIR
CONGEDO, MD, CAROL Z	ALLEGHENY
CONKLIN, MD, JAMES E	ALLEGHENY
CONKLIN, MD, WILLIAM T	ALLEGHENY
CONLIN, MD, EDWARD F	MERCER
CONLY, MD, FRANK L	CLINTON
CONN, MD, ANDREW R	DELAWARE
CONN, MD, FRANK W	CAMBRIA
CONN, MD, REX B	PHILADELPHIA
CONNAUGHTON, MD, JAMES F	CHESTER
CONNAUGHTON, MD, PATRICK N	LANCASTER
CONNELL, MD, JANET T	CHESTER
CONNELL, MD, THOMAS A	PHILADELPHIA
CONNELLY, DO, JOHN E	LEHIGH
CONNELLY, MD, MICHAEL E	MERCER
CONNER, MD, GEORGE H	LEBANON
CONNER, MD, J HUBERT	CHESTER
CONNER, MD, KENNETH B	DAUPHIN
CONNER JR, THOMAS K	STUDENT
CONNERTON, MD, GEORGE E	BERKS
CONNOLLY, MD, DAVID P	ALLEGHENY
CONNOLLY, GEOFFREY T	STUDENT
CONNOLLY, MD, MATTHEW J	LUZERNE
CONNOLLY, DO, WILLIAM S	SCHUYLKILL
CONNOR, DO, J MICHAEL	FRANKLIN
CONNOR, MD, KATHRYN M	YORK
CONNOR, MD, SUSAN A	CLARION
CONNORS, MD, CHARLES F	LACKAWANNA
CONNORS JR, MD, EARL K	BUCKS
CONRAD, MD, DONALD C	DAUPHIN
CONRAD, MD, JAMES L	BUCKS
CONRAD, MD, JOSEPH E	SCHUYLKILL
CONRAD, MD, REBECCA S	PHILADELPHIA
CONRAD, MD, WAYNE R	LANCASTER
CONRADY, MD, WILLIAM E	BEAVER
CONROY, DO, ELLEN D	DELAWARE
CONROY, DO, JAMES F	PHILADELPHIA
CONROY, MD, JOSEPH V	PHILADELPHIA
CONROY, KELLY J	STUDENT
CONROY, MD, WILLIAM P	ALLEGHENY
CONROY JR, DO, JOHN D	DAUPHIN
CONSIDINE, DO, KEVIN C	NORTHAMPTON
CONSOLI, MD, DEBORAH P	BERKS
CONSTANCE, MD, CHRISTOPHER G	DAUPHIN
CONSTANTIN, MD, LUIS	LEHIGH
CONSTANTINE, MD, GINGER D	DELAWARE
CONSTANTINE, MD, JAY J	DELAWARE
CONTE, MD, ROBERT R	WESTMORELAND
CONTE, MD, THOMAS E	ALLEGHENY
CONTI, MD, JOSEPH D	CHESTER
CONTI, MD, STEPHEN F	ALLEGHENY
CONTINO, MD, JOHN A	PHILADELPHIA
CONTRACTOR, MD, FARHAD M	ALLEGHENY
CONTRAFATTO, MD, DANIEL S	ALLEGHENY
CONWAY, MD, CYRIL F	LYCOMING
CONWAY, MD, DAVID C	ELK/CAMERON
CONWAY JR, JOSEPH L	STUDENT
COOK, MD, DAVID G	PHILADELPHIA
COOK, MD, DAVID R	ALLEGHENY
COOK, MD, DONALD H	CHESTER
COOK, MD, JAMES H	MONTGOMERY
COOK, MD, NICHOLAS A	NORTHAMPTON
COOK, MD, RALPH W	FAYETTE
COOK, MD, RANDALL C	WESTMORELAND
COOK, MD, RICHARD A	FAYETTE
COOK, MD, ROSEMARY A	PHILADELPHIA
COOK, MD, WILLIAM L	DELAWARE
COOK, MD, WILLIAM R	ALLEGHENY
COOK III, MD, HAROLD E	VENANGO
COOKE, MD, CURTIS W	VENANGO
COOKE JR, MD, ALFRED J	LANCASTER
COOKSEY, MD, STEPHEN H	ALLEGHENY
COONEY, MD, BRIAN S	PHILADELPHIA
COONEY, MD, MARINA J	PHILADELPHIA
COOPER, MD, ALAN E	ALLEGHENY
COOPER, MD, COLLEEN A	MONROE
COOPER, MD, DAVID R	LUZERNE
COOPER, MD, DONALD R	PHILADELPHIA
COOPER, MD, EDWARD I	PHILADELPHIA
COOPER, MD, EDWARD S	PHILADELPHIA
COOPER, MD, EMMETT M	LANCASTER
COOPER, MD, HARRY S	PHILADELPHIA
COOPER, MD, HELEN C	LUZERNE
COOPER, MD, JEANNE A	ALLEGHENY
COOPER, MD, JOSEPH E	LUZERNE
COOPER, MD, JOSEPH H	DELAWARE
COOPER, MD, KAREN	LUZERNE
COOPER, MD, KENNETH L	LYCOMING
COOPER, MD, MARJORIE R	PHILADELPHIA
COOPER, MD, MARK W	PHILADELPHIA
COOPER, MD, MATTHEW K	PHILADELPHIA
COOPER, MD, MAX M	PHILADELPHIA
COOPER, MD, MURRAY S	MONTGOMERY
COOPER, MD, WILLIAM M	ALLEGHENY
COOPER JR, MD, E NEWBOLD	DELAWARE
COOPER JR, MD, HERBERT K	LANCASTER
COOPEY, MD, F DONALD	LEBANON
COORAY, MD, CHARLES N	ALLEGHENY
COOVER, MD, LEONARD R	ERIE
COPE, MD, CONSTANTIN	PHILADELPHIA
COPE, MD, DAVID A	BERKS
COPE, MD, EDWIN S	CARBON
COPELAND, MD, ADRIAN D	PHILADELPHIA
COPELAND, MD, CHARLES E	ALLEGHENY
COPELAND, MD, MAIKE N	MONTOUR
COPELAND, MD, NATHANIEL H	PHILADELPHIA
COPELAND, VICKI D	STUDENT
COPLEY, MD, LAWSON A	PHILADELPHIA
COPPERMAN, MD, GERTRUDE	PHILADELPHIA
COPPES, MD, CHARLES D	PHILADELPHIA

COPPOLO, MD, BERNARD L	ELK/CAMERON
COPPOLO JR, MD, BERNARD L	INDIANA
COPPULA, MD, ROBERT J	WASHINGTON
COPPULA, MD, WILLIAM F	ALLEGHENY
CORALLO, MD, DIANE M	LANCASTER
CORAZZA, MD, LEO J	LUZERNE
CORBETT, MD, JOHN M	LAWRENCE
CORCINO JR, MD, BALTAZAR L	CLEARFIELD
CORCORAN, MD, ALBERT W	ALLEGHENY
CORCORAN, MD, JOHN J	LANCASTER
CORCORAN, MD, MICHAEL J	ALLEGHENY
CORDERO, MD, EDGAR C	ALLEGHENY
CORDERO, MD, HERMELINDA	LUZERNE
CORDOBA, MD, DIEGO R	ARMSTRONG
COREN, MD, ALFRED B	CLEARFIELD
COREN, MD, GARY S	PHILADELPHIA
COREY, MD, STEPHEN H	ALLEGHENY
CORFF, MD, MEYER	PHILADELPHIA
CORKERY, DO, THOMAS B	ALLEGHENY
CORKHILL JR, MD, ERIC A	MONTGOMERY
CORMIER, DO, LESLIE L	PHILADELPHIA
CORNACCHIA, DO, DAMIAN J	DELAWARE
CORNACCHIONE, DO, MARIO J	LUZERNE
CORNELL, MD, JAMES F	LEHIGH
CORNFIELD, MD, DENNIS B	PHILADELPHIA
CORNMAN III, MD, HENRY D	MONTGOMERY
COROSO, MD, JOSEPH G	ALLEGHENY
CORPUZ JR, MD, MARCELO B	ALLEGHENY
CORRADO JR, MD, CATALDO F	FAYETTE
CORRAL, MD, CELESTINO F	ALLEGHENY
CORRATO, MD, ROBERT R	MONTGOMERY
CORRELL, MD, DARIN J	STUDENT
CORRIGAN, MD, DOMINIC F	MONTGOMERY
CORSELLO, MD, GUY R	ALLEGHENY
CORSETTI, JEFFREY P	STUDENT
CORSO, MARK J	STUDENT
CORSON, MD, JOSEPH K	PHILADELPHIA
CORSON, MD, STEPHEN L	PHILADELPHIA
CORSON, MD, THOMAS C	COLUMBIA
CORTINA, MD, GARY J	ERIE
CORTINOVIS, MD, CHARLES R	WASHINGTON
CORTNER, MD, JEAN A	PHILADELPHIA
CORVASCE, MD, JOSEPH M	PHILADELPHIA
CORWIN, MD, DOUGLAS T	WASHINGTON
CORWIN JR, MD, DOUGLAS T	ALLEGHENY
COSGROVE, MD, JAMES L	ALLEGHENY
COSHAREK, MD, ROBERT F	INDIANA
COSLETT, MD, DOUGLAS S	LUZERNE
COSLETT, MD, MARTHA M Y	LANCASTER
COSSROW, MD, JOEL I	BEAVER
COSTA, EMILY J	STUDENT
COSTA, MD, FRANK J	ALLEGHENY
COSTA, MD, MARC L	ALLEGHENY
COSTA, MD, RONALD E	HUNTINGDON
COSTA-GRECO, MD, MARIA A	ALLEGHENY
COSTACURTA, MD, GARY A	NORTHAMPTON
COSTANTINO, MD, GEORGE N	BUCKS
COSTANZA, MD, AGATHA H	NORTHAMPTON
COSTARINO, MD, ANDREW T	PHILADELPHIA
COSTELLO, MD, GABRIELLE J	PHILADELPHIA
COSTELLO, MD, RALPH M	WESTMORELAND
COSTELLO, DO, THOMAS P	BUCKS
COSTLEIGH, MD, BRIAN J	PHILADELPHIA
COTLER, MD, JEROME M	PHILADELPHIA
COTLER, MD, MARC D	MONTGOMERY
COTTER, MD, JOHN T	WASHINGTON
COTTLE, MD, BETTY L	BLAIR
COTTLE, MD, HAROLD R	BLAIR
COTTON, MD, ERIC K	ALLEGHENY
COTTON, MD, JOY C L	DAUPHIN
COTTRELL, MD, DAVID C	NORTHMBRLAND
COUCH, MD, F BOYD	WESTMORELAND
COUKOS, MD, GEORGE	PHILADELPHIA
COULTER, MD, CLINTON R	CLARION
COURSIN, MD, DAVID B	LANCASTER
COURTNEY, MD, DREW E	LEBANON
COURTNEY, MD, WILLIAM B	WESTMORELAND
COUSINS, DO, TODD B	MCKEAN
COUSOUNIS, MD, GERRY T	PHILADELPHIA
COVALESKY, MD, VERONICA A	PHILADELPHIA
COVATTO, MD, ROSEANN H	ALLEGHENY
COVER, MD, KENNETH L	ALLEGHENY
COVERDALE, MD, PAUL J	BUCKS
COVERDALE III, MD, EDWARD J	BUCKS
COVINGTON, MD, DARELL T	MONROE
COWAN, MD, JAMES A	NORTHAMPTON
COWAN, MD, MICHAEL L	LANCASTER
COWAN, MD, THOMAS W	ALLEGHENY
COWITZ, MD, BERNARD	PHILADELPHIA
COWLEY, MD, ALLEN W	DAUPHIN
COX, E DARRIN	STUDENT
COX, DO, FRED A	CHESTER
COX, MD, JACK L	BEAVER
COX, MD, JAY S	CENTRE
COX, MD, JOHN B	CENTRE
COX, MD, LAURIE A	MIFFLIN/JUNIATA
COX, MD, N ADELE	PHILADELPHIA
COX, MD, PAUL A	CUMBERLAND
COX, MD, WALTER R	WASHINGTON
COYLE, MD, ALICE R	LACKAWANNA
COYLE, MD, JOHN J	LUZERNE
COYLE, MD, JOHNSON G	CUMBERLAND
COYLE, MD, ROBERT M	ALLEGHENY
COYLE, MD, SOPHIE J	ALLEGHENY
COYLE, MD, THOMAS J	BUCKS
COYLE, MD, WILLIAM A	DELAWARE
COYLE, MD, WILLIAM P	ALLEGHENY
COYNE, MD, VERONICA E	BUCKS
COZEN, MD, BENNETT H	MONTGOMERY
COZINE, MD, RICHARD A	LYCOMING
COZZA, DO, JOANN C	PHILADELPHIA
COZZA JR, MD, MICHAEL R	BEAVER
COZZARELLI, MD, JAMES D	MONTGOMERY
COZZONE, DO, MONICA L	LUZERNE
CRAGO, MD, H ROBERT	MERCER
CRAIG, MD, ANN M	PHILADELPHIA
CRAIG, MD, PAUL C	BERKS
CRAIG, MD, RICHARD A	YORK
CRAIN, MD, RICHARD H	ALLEGHENY
CRAKE, MD, ROGER F	COLUMBIA
CRAM, MD, ROBERT H	DELAWARE
CRAMER, DO, DAVID I	CENTRE
CRAMER, DO, LAURENCE V	MONTGOMERY
CRAMP, MD, LLOYD L	BERKS
CRAMTON, MD, DAVID C	LUZERNE
CRANDALL, MD, THEODORE L	ALLEGHENY
CRANDALL, MD, TONIE L	BERKS
CRANDALL III, MD, RICHARD A	LANCASTER
CRANE, FRANCINE T	STUDENT
CRANE, MD, RICHARD D	STUDENT
CRAPARO, MD, FRANK J	MONTGOMERY
CRAPARO, MD, JOCELYN L	DELAWARE
CRAPARO, MD, THOMAS J	LACKAWANNA
CRASTNOPOL, MD, DAVID H	BUCKS
CRAVETZ, MD, HOWARD	MONTGOMERY
CRAWFORD, MD, DONALD G	DAUPHIN
CRAWFORD, MD, GEORGE A	FRANKLIN
CRAWFORD, MD, PAMELA A	VENANGO
CRAWFORD, MD, PAUL H	DAUPHIN
CRAWFORD JR, MD, RALPH W	BLAIR
CRAWFORD-FAUCHER, AMY D	STUDENT
CRAYTON, MD, HEIDI JO	PHILADELPHIA
CREECH, MD, RICHARD H	PHILADELPHIA
CREEVY, MD, WILLIAM R	PHILADELPHIA
CREIGHTON JR, MD, DANIEL K	MIFFLIN/JUNIATA
CRESPO, DO, MANUEL O	ERIE
CRETEKOS, MD, CONSTANTINE J	ALLEGHENY
CRETELLA, MD, THOMAS S	COLUMBIA
CREVECOEUR, MD, CARLINE M	BLAIR
CREWS, DO, NAN I	LEBANON
CRIBBINS III, A JOSEPH	STUDENT
CRICHLOW, MD, AMRIL G	ALLEGHENY
CRIDER, MD, DONALD B	BLAIR
CRILL, MD, NORMAN C	LANCASTER
CRILLEY, DO, PAMELA ANN	PHILADELPHIA
CRINO, MD, JANET A	PHILADELPHIA
CRISPEN, MD, JAMES F	DAUPHIN
CRISPEN, MD, JOHN W	ADAMS
CRISPINO, MD, CHARLES M	ALLEGHENY
CRIST, MD, HENRY S	CUMBERLAND
CRISTOL, MD, JAMES L	PHILADELPHIA
CRITS, MD, HARRY J	MONTGOMERY
CRITTENDEN, MD, DONALD W	BUCKS
CRIVARO, MD, MICHAEL A	MONTGOMERY
CROCCO, TODD J	STUDENT
CROCK, MD, FREDERICK W	ALLEGHENY
CROCKETT, MD, ROBERT A	ALLEGHENY
CROLL, MD, MILLARD N	PHILADELPHIA
CROMO, MD, SANDRA A	ALLEGHENY
CRONIN, KATHLEEN T	STUDENT
CRONIN JR, MD, RANDALL C	LUZERNE
CRONKEY, MD, JOSEPH E	LACKAWANNA
CRONLEY, MD, SHEA ANN	PHILADELPHIA
CROSS, MD, RAQUEL	ERIE
CROSS JR, MD, SAMUEL	ARMSTRONG
CROSSETT, MD, LAWRENCE S	ALLEGHENY
CROSSEY, DO, ROBERT A	WESTMORELAND
CROTEAU, MD, J RUSSELL	DAUPHIN
CROWE, DO, CHRISTOPHER C	PHILADELPHIA
CROWLEY, MD, KURT R	PHILADELPHIA
CROWLEY, MD, PATRICIA A	ALLEGHENY
CROWTHER, JAMES D	STUDENT
CROYLE, MD, RAY W	WESTMORELAND
CROYLE, EXEC SEC, LUANN	ARMSTRONG
CROZIER, MD, KELLEY S	PHILADELPHIA
CRUCIANI, MD, MARK	LACKAWANNA
CRUCIANI JR, MD, DOMINICK A	LACKAWANNA
CRUDO, MD, CHITO M	WESTMORELAND
CRUFT, MD, GEORGE E	PHILADELPHIA
CRUMRINE, MD, RICHARD S	BEAVER
CRUZ, DENISE A	STUDENT
CRUZ, MD, EDGARDO S	LEHIGH
CRUZ, MD, LUIS J	PHILADELPHIA
CRUZ, MD, ROGELIO A	ERIE
CRUZ JR, MD, MOISES B	POTTER
CRYER, MD, THEODORE H	FRANKLIN
CRYSTLE, MD, C DEANS	LANCASTER
CSIKOS, MD, DAVID A	CAMBRIA
CSIR, MD, FLOYD M	ERIE
CUBINA, DO, MARIA D	PHILADELPHIA
CUBLER, MD, EDWARD W	SCHUYLKILL
CUCINOTTA, MD, SALVATORE	PHILADELPHIA
CUDDEBACK, MD, THOMAS J	ALLEGHENY
CUDDY, MD, VINCENT D	BEAVER
CUELLO-SUAREZ, MD, ROSA M	PHILADELPHIA
CULF, MD, NORRIS K	PHILADELPHIA
CULIG, MD, CARL A	ALLEGHENY
CULIG, MD, MICHAEL H	ALLEGHENY
CULLEN, MD, ESKER W	CENTRE
CULLEN, DO, MAUREEN P	ALLEGHENY
CULLEY, MD, ANDREW W	BEAVER
CULLINEY, MD, JOHN J	LACKAWANNA
CULOTTA, MD, DOMINIC A	BUCKS
CULP, MD, BRUCE R	MONTGOMERY
CULP, MD, RANDALL W	PHILADELPHIA
CULYBA, MD, MICHAEL J	BEAVER
CUMMINGS, MD, PETER D	DAUPHIN
CUMMINGS, MD, ROBERT V	LEHIGH
CUMMINGS III, MD, CARY	DAUPHIN
CUNARD, RENA B	STUDENT
CUNNANE, MD, MARY F	PHILADELPHIA
CUNNINGHAM, MD, PETER L	NORTHAMPTON
CUNNINGHAM, MD, WILLIAM L	WASHINGTON
CUPINO, MD, ELMER	CLEARFIELD
CURANZY, MD, RAYMOND R	LEBANON
CURCI, MD, JOSEPH J	BUCKS
CURCILLO, MD, PAUL G	PHILADELPHIA
CURLEY, DO, JOHN F	PHILADELPHIA
CURLEY, DO, ROBERT M	LACKAWANNA
CURLEY, TIMOTHY M	STUDENT
CURRAN, MD, MARILYN R	MONTGOMERY
CURRID, MD, AIDEEN M	MONTOUR
CURRIE, MD, PHILIP W	WESTMORELAND
CURRIE, MD, RICHARD J	PHILADELPHIA
CURRY, HEATHER A	STUDENT
CURRY, MD, THOMAS A	SCHUYLKILL
CURTIN, MD, ANDREW J	MONTGOMERY
CURTIN, MD, CHARLES T	LACKAWANNA
CURTIN, MD, EUGENE A	LACKAWANNA
CURTIN, MD, HUGH D	ALLEGHENY
CURTIS, MD, JAMES L	MONTOUR
CUSANO, DO, WILBERT A	ALLEGHENY
CUSHING, MD, WILLIAM T	WASHINGTON
CUSICK, MD, RICHARD J	LEHIGH
CUSTER, MD, CHRISTOPHER C	MIFFLIN/JUNIATA
CUSTER, MD, DIANE E	MONTGOMERY
CUSTODIO, MD, EDGARDO C	LEHIGH
CUTHBERTSON, MD, RAND J	CUMBERLAND
CUTILLO, MD, DOUGLAS P	LACKAWANNA
CUTLER, MD, CHARLES	MONTGOMERY
CUTLER, MD, IRVIN	PHILADELPHIA
CUTLER, MD, JOHN C	ALLEGHENY
CUTLER, MD, ROBERT S	CHESTER
CUTLER, MD, STANLEY M	ALLEGHENY
CUTRY, MD, JOSEPH J	POTTER
CUTULY, MD, EUGENE	ALLEGHENY
CUYEGKENG-JOSE, MD, CYNTHIA	LUZERNE
CUZZOCREA, CHRISTINE M	STUDENT
CWIK, MD, JOHN C	CAMBRIA
CYGAN, MD, DAVID J	ALLEGHENY
CYNN, MD, WON S	PHILADELPHIA
CYPHER, MD, RONALD L	BUTLER
CZAJKOWSKI, MD, THOMAS J	LEHIGH
CZARNECKI, MD, CASIMIR	PHILADELPHIA
CZARNECKI, MD, DOROTHY G	PHILADELPHIA
CZARNECKI, JOSEPH J	STUDENT
CZARNECKI, MD, NANCY S	PHILADELPHIA
CZUBA, MD, MICHAEL T	WESTMORELAND
CZULEWICZ, DO, LAURA L	ALLEGHENY
CZWALINA, DO, ROBERT	LUZERNE

D

D'AGATA, MD, SAMUEL D	YORK
D'ALESSIO, MD, ANTHONY	ALLEGHENY
D'ALONZO, MD, WALTER A	PHILADELPHIA
D'AMICO, MD, ANTHONY V	PHILADELPHIA
D'AMORE, MD, DAVID L	MERCER
D'ANCA, MD, ALFRED F	LUZERNE
D'ANDREA, MD, DENISE M	PHILADELPHIA
D'ANDREA, DO, JEFFERY P	PHILADELPHIA
D'ANDREA, DO, JOHN W	HUNTINGDON
D'ANGELO, DO, DAVID W	DELAWARE
D'ANTONIO, MD, JAMES A	ALLEGHENY
D'EMILIO, MD, TERRANCE A	WESTMORELAND
D'INNOCENZO, MD, RICHARD A	MONTGOMERY
D'IORIO, MD, JAMES P	LUZERNE
D'IORIO, MD, NORINA M	LUZERNE
D'ONOFRIO, MD, MATTHEW A	ALLEGHENY
D'URSO, MD, FRANCESCO	CHESTER
DABB, MD, RICHARD W	YORK
DABBACK, MD, DEWITT T	CHESTER
DACOSTA, MD, ANNA-MARIA M	PHILADELPHIA
DACOSTA, MD, JOHN B	ALLEGHENY
DADDARIO, MD, RICHARD T	BUCKS
DADPARVAR, MD, SIMIN D	PHILADELPHIA
DAFTARY, MD, SUDHIR R	LAWRENCE
DAGEN, MD, J EDWARD	CUMBERLAND
DAGEN, DO, ROSE M	FRANKLIN
DAGHESTANI, MD, AIMAN N	CRAWFORD
DAGHIR, MD, JOHN N	CHESTER
DAGOSTINO, MD, FRANK J	NORTHAMPTON
DAHMUS, MD, ROBERT R	DAUPHIN
DAHODWALA, MD, IDRIS Z	PHILADELPHIA
DAIL, MD, E MICHAEL	ERIE
DAILEY, MD, EDWARD G	DAUPHIN
DAILEY, MD, ELLEN E	ERIE
DAILEY, MD, JAMES P	ERIE
DAILEY, MD, JOHN R	DAUPHIN
DAINESI, MD, EDWARD G	ALLEGHENY
DAIT, MD, JOSE E	CARBON
DAITER, MD, DONALD	PHILADELPHIA
DAJANI, MD, ZUHDI M	CLARION
DALAL, MD, UMESH I	MONROE
DALBY, MD, PATRICIA L	ALLEGHENY
DALE, MD, ANTHONY D	PHILADELPHIA
DALE JR, MD, HIRAM T	NORTHAMPTON
DALEY, MD, MARVIN C	LANCASTER
DALLAIRE, MD, LOUISE A I	POTTER
DALLAS-FEENEY, DO, SUSAN	CHESTER
DALONI, MD, PETER M	MERCER
DALSEY, MD, ROBERT M	PHILADELPHIA
DALSEY, MD, WILLIAM C	PHILADELPHIA
DALTNER, MD, CARL J	ALLEGHENY
DALTON, MD, BRIAN E	ERIE
DALTON, MD, CHARLES M	CENTRE
DALY, MD, CHRISTOPHER J	ALLEGHENY
DALY, MD, CHRISTOPHER X	MONTGOMERY
DALY, MD, DAVID G	BERKS
DALY, MD, MARGARET A	ALLEGHENY
DALY JR, MD, FRANCIS T	CLINTON
DALY JR, MD, JAMES F	DAUPHIN
DALY JR, MD, PETER F	ALLEGHENY
DALY JR, MD, RICHARD H	YORK
DAMAZO, MD, ELPIDIO D	BEAVER
DAMAZO, MD, NATIVIDAD S	BEAVER
DAMESHEK, MD, H LEE	ALLEGHENY
DAMIANO, DO, JOHN A	LANCASTER
DAMIANO, MD, MICHAEL D	DELAWARE
DAMIANO, MD, ROBERT E	CHESTER
DAMM, MD, CHRISTOPHER J	BERKS
DAMSKER, JASON A	STUDENT
DAMSKER, MD, JEFFREY I	PHILADELPHIA
DAMSKER, KEITH E	STUDENT
DANA, MD, IHAB	SUSQUEHANNA
DANAEE, MD, NOSRATOLLAH	ALLEGHENY
DANAIE, MD, JAMSHID	BEAVER
DANCHA, DO, ANDREW J	PHILADELPHIA
DANDEGIAN, MD, ALBERT N	PHILADELPHIA
DANGELO, MD, GEORGE J	ERIE
DANGVU, ANGELA S W	STUDENT
DANIEL, MD, STEPHEN D	BEAVER
DANIELE, MD, JOSEPH Q	ERIE
DANIELS, MD, DAN	JEFFERSON
DANIELS, MD, MICHAEL O	CUMBERLAND
DANIELS JR, MD, GEORGE F	BEAVER
DANISHANKO, MD, ALBERT G	LUZERNE
DANKMYER, MD, FREDERICK L	SCHUYLKILL
DANKO, MD, EUGENE T	ALLEGHENY
DANNEKER, MD, DALE A	CENTRE
DANNY, DO, MADELINE A	MONTGOMERY
DANOFF, MD, DAVID M	MONTGOMERY
DANOFF, MD, MIKE	ALLEGHENY
DANTE, MD, STEPHEN J	PHILADELPHIA
DANTZIC, MD, SONDRA	PHILADELPHIA
DANTZIG, MD, PAUL I	MONTGOMERY
DANYO, MD, J JOSEPH	YORK
DANZI, MD, JOSEPH T	PHILADELPHIA
DANZIS, DO, JEFFREY J	BUCKS
DAPPERT, MD, BARBARA A	ALLEGHENY
DARNELL, MD, RICHARD I	BUCKS
DAROSKI, MD, M SABINA	ALLEGHENY
DAROWISH, DO, CHARLES E	DAUPHIN
DARRELL, MD, JOHN C	ALLEGHENY
DAS, MD, AMIT	LACKAWANNA
DAS, MD, ANURAG K	MONTGOMERY
DAS, MD, NIRODE C	LUZERNE
DAS, SAURABH B	STUDENT
DASCHER JR, MD, JOHN J	MONTGOMERY
DASH-MODI, MD, ANITA	ALLEGHENY
DASHE, MD, MYER M	BERKS
DASHEIFF, MD, RICHARD M	ALLEGHENY
DASTUR, MD, KHURSHED J	ALLEGHENY
DATLOF, MD, STEVEN B	BERKS
DATTA, MD, SATYA P	MONTGOMERY
DATTA, MD, TAPAN D	WESTMORELAND
DATTILO, MD, JAMES T	ALLEGHENY
DAUGHERTY, MD, DONALD	YORK
DAUGHERTY, MD, JAMES H	LANCASTER
DAUGHTRY, DO, GLEN R	CUMBERLAND
DAUM, MD, GARY S	DELAWARE
DAURIA, MD, THOMAS M	FAYETTE
DAVE, MD, DEEPAK V	LUZERNE
DAVE, MD, KAILAS D	LUZERNE
DAVE, MD, NIKHIL K	ALLEGHENY
DAVID, MD, ARTHUR	ALLEGHENY
DAVID, MD, JEFFREY W	ARMSTRONG
DAVID, MD, MARIAN	MONTGOMERY
DAVIDES, MD, KYRIAKOS C	ALLEGHENY
DAVIDOFF, MD, FRANK F	PHILADELPHIA
DAVIDOWSKI, MD, THOMAS A	CENTRE
DAVIDSON, MD, BRUCE L	PHILADELPHIA
DAVIDSON, MD, GARY M	CAMBRIA
DAVIDSON, MD, JAY H	PHILADELPHIA
DAVIDSON, MD, PAUL R	LANCASTER
DAVIDSON, MD, RICHARD S	PHILADELPHIA
DAVIDSON, RICHARD S	STUDENT
DAVIDSON, MD, STEVEN J	PHILADELPHIA
DAVIDSON JR, MD, WILLIAM R	LEBANON
DAVIE, MD, FRANK M	WESTMORELAND
DAVIES, MD, MATTHEW F	DAUPHIN
DAVIES, MD, ROBERT J	BUCKS
DAVILA, MD, RAMON A	MERCER
DAVIS, MD, ABBY T L	STUDENT
DAVIS, MD, ALLAN S	LANCASTER
DAVIS, MD, CAROLINE K	DAUPHIN
DAVIS, MD, DANIEL T	LUZERNE
DAVIS, MD, DENNIS	WASHINGTON
DAVIS, MD, DONNA J S	DAUPHIN
DAVIS, MD, EARL C	YORK
DAVIS, MD, EARLE R	ALLEGHENY
DAVIS, MD, EDWARD W	MONTGOMERY
DAVIS, MD, H ROBERT	CUMBERLAND
DAVIS, MD, HAROLD J	LACKAWANNA
DAVIS, MD, HARRIET J	BUCKS
DAVIS, MD, HELEN A P	WESTMORELAND
DAVIS, MD, IRENE B	LANCASTER
DAVIS, MD, JAMES H	YORK
DAVIS, MD, JAMES H	LANCASTER
DAVIS, MD, JAMES K	CAMBRIA
DAVIS, MD, JOHN S	ALLEGHENY
DAVIS, MD, JOHN W	PHILADELPHIA
DAVIS, DO, LEE W	LACKAWANNA
DAVIS, MD, MARK E	NORTHAMPTON
DAVIS, DO, NEAL M	LACKAWANNA

DAVIS, MD, PAUL K	DELAWARE
DAVIS, MD, PETER L	ALLEGHENY
DAVIS, MD, RAYMOND C	SUSQUEHANNA
DAVIS, MD, RICHARD L	DAUPHIN
DAVIS, MD, RINA C	PHILADELPHIA
DAVIS, MD, ROBERT H	DAUPHIN
DAVIS, MD, ROBERT M	YORK
DAVIS, MD, ROBERT V	LACKAWANNA
DAVIS, MD, STUART M	TIOGA
DAVIS, MD, THOMAS S	DAUPHIN
DAVIS, MD, TODD R	ALLEGHENY
DAVIS, MD, WILLIAM F	WAYNE/PIKE
DAVIS, MD, WILLIAM L	FRANKLIN
DAVIS, MD, WILLIAM S	DAUPHIN
DAVIS JR, MD, EDWARD T	BEAVER
DAVITCH, MD, LEONARD S	PHILADELPHIA
DAVOLI, MD, ROBERT L	WESTMORELAND
DAWGERT, MD, F DENNIS	LACKAWANNA
DAWSON, MD, MICHAEL H O	SCHUYLKILL
DAWSON, MD, REESE E	ALLEGHENY
DAWSON, MD, ROBERT R	ALLEGHENY
DAY, MD, H JAMES	MONTGOMERY
DAY JR, MD, RICHARD W	ALLEGHENY
DE, MD, NIRMAL K	PHILADELPHIA
DE ANGELIS, MD, MICHAEL A	PHILADELPHIA
DE ANGELO, MD, FRANK J	PHILADELPHIA
DE BERNARDO JR, ROBERT L	STUDENT
DE FRANCESCH, MD, GIULIANA I	PHILADELPHIA
DE JULIA, MD, JEROME J	LAWRENCE
DE LIA, DO, FRANK A	PHILADELPHIA
DE MARCO, MD, ANDREW D	ALLEGHENY
DE MASI, MD, ROCCO J	YORK
DE MEIRA, MD, ELIO D	MERCER
DE MEO, MD, PATRICK J	ALLEGHENY
DE PASQUALE, MD, STEPHEN E	PHILADELPHIA
DE PIETRO, MD, MICHAEL R	PHILADELPHIA
DE PILLIS, MD, VINCENT J	MONTGOMERY
DE RENNE, AIDON H	STUDENT
DE RIENZO, MD, UMBERTO A	WASHINGTON
DE RIVAS, MD, CARMELA F	MONTGOMERY
DE SANTIS, MD, DONALD	DELAWARE
DE SANTOS, MD, MARCELINO A	BUCKS
DE SOTO, MD, DANILO A	LACKAWANNA
DE VRIES, MD, EGBERT J	ALLEGHENY
DEAKIN, DO, SUSAN	ALLEGHENY
DEAN, MD, JAMES L	LACKAWANNA
DEAN, MD, ROBERT J	ALLEGHENY
DEANGELIS, DO, PATRICIA A	LEHIGH
DEANTONIO, MD, ANGELA M	MONTOUR
DEARDORFF, MD, CHARLES L	LANCASTER
DEAROLF III, MD, WALTER W	MONTGOMERY
DEAS, MD, THOMAS C	PHILADELPHIA
DEBAKKER, MD, CAROL J	DELAWARE
DEBALLI, PETER	STUDENT
DEBENEDICTIS, MD, KENNETH J	BERKS
DEBERARDINIS, MD, CAMILLO T	PHILADELPHIA
DEBERARDINIS, RALPH J	STUDENT
DEBIAS, MD, DENNIS A	BERKS
DEBIASSE, MD, TIMOTHY A	WESTMORELAND
DEBONIS, MD, CHARLES S	LUZERNE
DEBROFF, MD, BRIAN M	ALLEGHENY
DEBUQUE, DO, JEFFERY A	LEHIGH
DECARLO, MD, JOHN P	PHILADELPHIA
DECARO, MD, MARY M	DELAWARE
DECARO, MD, MATTHEW V	PHILADELPHIA
DECASTRO, MD, MIGUEL A	PHILADELPHIA
DECASTRO, MD, NIEVES D	PHILADELPHIA
DECHERNEY, MD, WILLIAM A	PHILADELPHIA
DECKER, MD, GARY R	LUZERNE
DECKER, MD, JOHN P	PHILADELPHIA
DECKER, MD, PETER G	LUZERNE
DECKER, MD, RICHARD L	BLAIR
DECOSMO, MD, VINCENT J	WESTMORELAND
DECURTIS, MD, GEORGE M	LUZERNE
DEDHIA, MD, CHAMPAK	LUZERNE
DEDIO, MD, ROBERT M	LEHIGH
DEE, MD, CECILIO C	MCKEAN
DEEB, MD, RAMON J	LEHIGH
DEES, MD, TERENCE D	DAUPHIN
DEES-PORCH, MD, FRANCES	DELAWARE
DEFABO, MD, FRANCIS L	WESTMORELAND
DEFALCIS, MD, DANIEL C	STUDENT
DEFALCIS, DO, DELPHY F	DELAWARE
DEFAY, MD, STANLEY D	BLAIR
DEFORNO, MD, DONALD J	MCKEAN
DEFRANCESCO, MD, CHARLES A	WESTMORELAND
DEFRANCISCO, MD, LANCE C	BLAIR
DEFRANCISCO, MD, MARY E	MONTGOMERY
DEFRANCO, MD, ALBERT B	NORTHAMPTON
DEFRANCO, MD, JOSEPH M	ERIE
DEFRANCO, MD, RICHARD J	ERIE
DEGENNARO, MD, LOUIS P	LACKAWANNA
DEGENNARO, MD, PATRICK J	LUZERNE
DEGLIN, MD, EDWARD A	MONTGOMERY
DEGREEN, MD, HYATT P	LANCASTER
DEGREGORIO, MD, NICHOLAS	ALLEGHENY
DEGREGORY, DO, THOMAS R	WESTMORELAND
DEGROOF, MD, ELLEN P L	BUCKS
DEGUZMAN-CAM, MD, BRIGIDA	DELAWARE
DEHAAS, MD, DAVID R	WASHINGTON
DEHART, MD, DAVID A	ALLEGHENY
DEHORATIUS, MD, RAPHAEL F	PHILADELPHIA
DEIBERT, MD, DAVID C	BERKS
DEIBERT, MD, EDWARD B	NORTHAMPTON
DEILY, MD, RAYMOND E	NORTHAMPTON
DEIMEL, MD, JOSEPH F	ERIE
DEIN, MD, ROBERT A	MONTGOMERY
DEININGER, MD, JOHN T	PHILADELPHIA
DEISHER, MD, SAMUEL W	YORK
DEITCH, MD, BERNARD	PHILADELPHIA
DEITCH, JOHN R	STUDENT
DEITCH, MD, MARC W	PHILADELPHIA
DEITRICK, DO, DAVID J	ALLEGHENY
DEITRICK, MD, JOHN E	MONTOUR
DEITRICK, MD, RICHARD E	ALLEGHENY
DEITRICK JR, MD, GEORGE A	NORTHMBRLAND
DEITZ III, MD, GEORGE W	MONTGOMERY
DEITZLER, MD, MARGARET M	PHILADELPHIA
DEJESUS, MD, ROBERT	WESTMORELAND
DEJESUS JR, MD, ROMAN Y	BEAVER
DEKONING, MD, JOHANNES L	BLAIR
DEKRET, MD, JEFFREY J	PHILADELPHIA
DEKRUIF, MD, HENDRIK	CRAWFORD
DEL GAUDIO, WALTER R	STUDENT
DEL VILLAR, MD, HUGO E	CHESTER
DELA TORRE, MD, HENRY G	JEFFERSON
DELACRUZ, MD, SILVESTRE S	DAUPHIN
DELAFUENTE, MD, CARLOS F	DAUPHIN
DELANEY, MD, CHRISTOPHER S	PHILADELPHIA
DELAPLANE, MD, JAMES M	PHILADELPHIA
DELASALAS, MD, ERNESTO M	BEDFORD
DELBIANCO, MD, PAUL R	ALLEGHENY
DELCASTILLO, MD, JUAN J	NORTHMBRLAND
DELEHANTY, MD, THOMAS J	LUZERNE
DELEO, MD, CAESAR A	LACKAWANNA
DELEO, MD, NICHOLAS V	LACKAWANNA
DELERME, MD, AUGUSTO N	BLAIR
DELGADO, MD, JUAN F	NORTHMBRLAND
DELGALVIS, MD, SUSAN C	LYCOMING
DELGATTO, MD, LOUIS J	COLUMBIA
DELGRANDE, MD, RICHARD E	BEAVER
DELGRIPPO, MD, GERARD A	CLINTON
DELGUERCIO, MD, EDMUND T	DELAWARE
DELL, MD, DAVID A	CUMBERLAND
DELLA ROSA JR, MD, JOHN J	LUZERNE
DELLAROSE, LAURIE A	STUDENT
DELLAVECCHIA, MD, MICHAEL A	MONTGOMERY
DELLINGER, MD, KAY A	DAUPHIN
DELMUNDO, MD, M ANGELI C	ALLEGHENY
DELO, MD, JEFFREY S	YORK
DELOGLOS, MD, GUST	ALLEGHENY
DELONE, MD, CARRIE L	DAUPHIN
DELONE, MD, J BRET	DAUPHIN
DELONE JR, MD, CHARLES A	DAUPHIN
DELONE JR, MD, FRANCIS X	DELAWARE
DELONG, MD, BRIAN S	DAUPHIN
DELONG, MD, STEPHEN R	ALLEGHENY
DELONG JR, MD, WILLIAM G	PHILADELPHIA
DELP, MD, DANIEL L	HUNTINGDON
DELP, MD, WILLIAM T	YORK
DELP JR, MD, CHARLES W	BERKS
DELROSARIO, MD, VIVENCIO G	DAUPHIN
DELSERONE, MD, EUGENE W	ALLEGHENY
DELSERRA, MD, JOSEPH J	LACKAWANNA
DELVECCHIO, MD, FREDESUINDA P	BUCKS
DELVECCHIO, MD, LEONARD M	BERKS
DELVECCHIO JR, MD, LEONARD M	MIFFLIN/JUNIATA
DEMARCO, MD, JAMES C	PHILADELPHIA
DEMARCO, MD, JOHN J	ERIE
DEMARIA JR, MD, PETER A	PHILADELPHIA
DEMARINO, MD, DAVID P	ALLEGHENY
DEMARIO JR, MD, RALPH C	LACKAWANNA
DEMASI, MD, PANTALEONE	PHILADELPHIA
DEMATTEIS, MD, JAMES A	ERIE
DEMBE, MD, CAROL R	PHILADELPHIA
DEMEDIO, MD, GABRIEL A	ALLEGHENY
DEMEDIO, MD, WILLIAM J	DELAWARE
DEMEZZA, MD, ANGELO	WESTMORELAND
DEMICHELE, MD, ANDREW H	PHILADELPHIA
DEMILIO, MD, MARY T	YORK
DEMJANENKO, MD, PAUL	ERIE
DEMKO, MD, JOSEPH N	LACKAWANNA
DEMOPOULOS, MD, JAMES T	PHILADELPHIA
DEMOS, MD, JACK	ALLEGHENY
DEMPSEY, MD, DANIEL T	PHILADELPHIA
DEMPSEY, MD, EUGENE C	PHILADELPHIA
DEMPSEY, MD, WILLIAM J	LACKAWANNA
DEMPSHER, MD, JOHN	CHESTER
DEMUTH, MD, CYNTHIA T	DAUPHIN
DEMUTH, MD, WILLIAM W	DAUPHIN
DEMUTH JR, MD, WILLIAM E	CUMBERLAND
DENARO, MD, ANTHONY T	LUZERNE
DENBY, MD, ROBERT A	BERKS
DENCH JR, MD, EDWARD H	CENTRE
DENDE, DO, PAUL F	LACKAWANNA
DENGLER, MD, ERNEST H	BERKS
DENICK, MD, CHERYL A	PHILADELPHIA
DENIS, MD, LEONARD J	LACKAWANNA
DENIZARD, MD, CARL E	PHILADELPHIA
DENLINGER, MD, JOHN K	LANCASTER
DENNEHY, MD, JOHN J	MONTOUR
DENNIS, MD, JAMES B	COLUMBIA
DENOVAN, MD, RICHARD E	PHILADELPHIA
DENT, MD, THOMAS L	MONTGOMERY
DENTE, MD, JOSEPH B	LACKAWANNA
DEORAS, MD, KIRAN S	ALLEGHENY
DEPACE, MD, NICHOLAS L	PHILADELPHIA
DEPAMPHILIS, MD, HY J	YORK
DEPAOLI, MD, ROSEMARY T	COLUMBIA
DEPAULA, MD, CARL J	PHILADELPHIA
DEPENA, MD, CHARLES A	BUCKS
DEPMAN, MD, STANLEY T	PHILADELPHIA
DEPP-HUTCHINSON, MD, WILLIAM S	HUNTINGDON
DEQUEVEDO, MD, ROBERT F	MONROE
DERASSE, MD, ALAIN R	NORTHAMPTON
DERASSE, MD, JUDITH R	NORTHAMPTON
DEREWITZ, MD, DANIEL L	YORK
DERISO, MD, BARBARA M	ALLEGHENY
DERIVAN, MD, ALBERT T	DELAWARE
DERIVAUX, MD, CHRISTOPHER C	PHILADELPHIA
DERK, MD, CHRIS T	STUDENT
DERKRIKORIAN, MD, HAGOP L	DELAWARE
DEROJAS, MD, JUAN J	LUZERNE
DEROSIMO JR, JOHN F	STUDENT
DERR, MD, CRAIG A	BERKS
DERR, DO, JOSE F	COLUMBIA
DERR, MD, RUSSELL H	LANCASTER
DERRICK, MD, BRUCE M	BUCKS
DERRICK, MD, DAVID A	YORK
DERSH, MD, JEROME	BERKS
DERSHAW, MD, BRUCE B	BUCKS
DERSTINE, MD, RALPH L	MONTGOMERY
DESAI, MD, AJIT M	PHILADELPHIA
DESAI, MD, ANSUYA M	MONTGOMERY
DESAI, MD, ARUNDEV D	LACKAWANNA
DESAI, MD, ARVIND D	LACKAWANNA
DESAI, MD, JAYESH B	SOMERSET
DESAI, MD, JITENDRA M	ALLEGHENY
DESAI, MD, KASHMIRA A	LACKAWANNA
DESAI, MD, KIRITKUMAR T	PHILADELPHIA
DESAI, MD, MEENA B	LACKAWANNA
DESAI, MD, PRAFUL V	WESTMORELAND
DESAI, DO, PRAGNESH A	LEHIGH
DESAI, MD, SARYU J	ALLEGHENY
DESAI, MD, SHIRISHKUMAR B	FAYETTE
DESAI, MD, SHIVRAJ J	MONTGOMERY
DESANTIS, MD, LUIGI	BUCKS
DESANTOLA, MD, JOSEPH R	PHILADELPHIA
DESCIAK, EDWARD B	STUDENT
DESHPANDE, MD, SHARADCHANDRA	ERIE
DESHPANDE, MD, VILAS K	LEHIGH
DESIMONE, GARY A	STUDENT
DESIMONE, DO, SALVATORE D	PHILADELPHIA
DESSABLES, MD, DANIEL R	BUCKS
DESSEN, MD, EDGAR L	LUZERNE
DESTEFANO, MD, DENNIS M	DAUPHIN
DETHOFF, MD, JOHN C	BERKS
DETHOMAS, MD, RONALD S	MIFFLIN/JUNIATA
DETKE, MICHAEL J	STUDENT
DETRE, MD, THOMAS	ALLEGHENY
DETUERK, MD, JOHN J	PHILADELPHIA
DETULLIO, MD, ANTHONY E	PHILADELPHIA
DETWEILER, EXEC DIR, JOHN S	BUCKS
DEUTSCH, MD, ELLEN S	PHILADELPHIA
DEUTSCH, MD, JOEL	PHILADELPHIA
DEUTSCH, MD, MELVIN	ALLEGHENY
DEUTSCH JR, MD, E THOMAS	CHESTER
DEVAN, MD, W TODD	YORK
DEVAUGHN, MD, GERALD L	PHILADELPHIA
DEVELIN, MD, EDWARD D	CAMBRIA
DEVENNEY, MD, JOHN E	MONTGOMERY
DEVENUTO JR, MD, JOSEPH J	BUCKS
DEVER, MD, MARIA T	DAUPHIN
DEVINE, MD, JEAN K	MONTGOMERY
DEVINE, MD, MARYANN	PHILADELPHIA
DEVINE, MD, MICHAEL F	MONTGOMERY
DEVINE, MD, PETER J	BUCKS
DEVINE, MD, RAYLENE A	BERKS
DEVINEY, MD, JOHN P	MONTGOMERY
DEVINNEY-WARD, DO, COLLEEN A	ALLEGHENY
DEVITA, MD, MICHAEL L	MIFFLIN/JUNIATA
DEVITA, MD, JENNIS M	MIFFLIN/JUNIATA
DEVITTORIO, MD, ARMOND A	JEFFERSON
DEVRIES, MD, JAN R J	SOMERSET
DEVRYER, MD, JOHANNA M	ALLEGHENY
DEWAR II, MD, WILLIAM R	WAYNE/PIKE
DEWEER-AVILES, MD, ANN M	MONTGOMERY
DEWIS, MD, LESTER S	CHESTER
DEX, MD, WALTER J	LEHIGH
DEYSHER, DO, DAVID P	MONTOUR
DHADUK, MD, NARENDRA V	LEBANON
DHADUK, MD, VITHALBHAI D	LACKAWANNA
DHAGAT, MD, SATISHCHANDRA	BEAVER
DHALIWAL, MD, RANJIT S	ERIE
DHAMI, MD, MANDEEP S	JEFFERSON
DHAWAN, MD, MANISH K	ALLEGHENY
DHAWAN, MD, RAM L	ALLEGHENY
DHAWER, MD, VIRENDER P S	CAMBRIA
DHEEN, MD, MOHAMED H R	LAWRENCE
DHILLON, SALENA	STUDENT
DI CAMILLO, VITO J	STUDENT
DI GIOVINE, MD, NICK M	ALLEGHENY
DI MARCO, DO, DANIEL T	ERIE
DI MARCO, MD, DAVID B	ARMSTRONG
DI TIZIO, MD, ROBERT P	MONTGOMERY
DIAKIW, MD, JOHN	LACKAWANNA
DIAMANTONI, MD, STEPHEN G	LANCASTER
DIAMOND, MD, B FRANKLIN	MONTGOMERY
DIAMOND, MD, DANIEL L	ALLEGHENY
DIAMOND, MD, GARY R	PHILADELPHIA
DIAMOND, MD, HERBERT S	ALLEGHENY
DIAMOND, MD, MARK	ALLEGHENY
DIAMOND, MD, PAUL M	WAYNE/PIKE
DIAMOND, DO, STEVEN M	NORTHAMPTON
DIAZ, MD, FLORIEL P	CARBON
DIAZ, MD, RENATO T	LUZERNE
DIAZ, MD, VICTOR A	PHILADELPHIA
DIBATTISTE, MD, PETER M	PHILADELPHIA
DIBBERN JR, DONALD A	STUDENT
DIBELLO, MD, ANGELO M	PHILADELPHIA
DIBELLO JR, MD, JOSEPH N	PHILADELPHIA
DIBENEDETTO, MD, THOMAS D	LEHIGH
DICENZO, DO, FRANK D	ALLEGHENY
DICENZO, MD, VALENTINA E	ALLEGHENY
DICKENS, MD, HELEN O	PHILADELPHIA
DICKEY, MD, ROBERT F	MONTOUR
DICKSON JR, MD, THOMAS B	LEHIGH
DICKSTEIN, MD, BENJAMIN	PHILADELPHIA
DICKTER, MD, JANICE H	CHESTER
DICKTER, MD, STEVEN J	CHESTER
DICOLA, MD, NANCY M	ALLEGHENY
DICONCETTO, MD, JOSEPH A	NORTHAMPTON
DICUCCIO, MD, NICHOLAS W	CLINTON
DICUCCIO, MD, WILLIAM A	BUTLER
DIDDLE, MD, KENNETH W	WESTMORELAND
DIEDERICH, MD, CHARLES F	ALLEGHENY
DIEFENBACH, MD, WILLIAM P	ERIE
DIEFES, MD, GERARD J	PHILADELPHIA
DIEGEL, MD, JOAN E	ALLEGHENY
DIEGO, MARIANNE B	STUDENT
DIEHL, MD, STEVEN L	BLAIR
DIENER, MD, IAN L	MONTGOMERY
DIENHART, MD, KARL J	BRADFORD
DIEPHAUS, MD, MARY E	DELAWARE
DIETEMAN, MD, DAVID F	ERIE
DIETL, MD, CHARLES A	MONTOUR
DIETLY, MD, ROBIN Z	ALLEGHENY
DIETRICH, ALISON E	STUDENT
DIETRICH, MD, HENRY T	CLINTON
DIETRICH, DO, LEONARD M	BERKS
DIETRICH, DO, MALCOLM H	YORK
DIETRICH, DO, MARCIA C	BERKS
DIETRICH, MD, SCOTT A	BERKS
DIETRICH, THOMAS J	STUDENT
DIETRICH, MD, WARREN C	NORTHAMPTON
DIETRICK, MD, RONALD A	BLAIR
DIEZ, MD, CHARLES M	ALLEGHENY
DIGIACOMO, MD, J CHRISTOPHER	BUCKS
DIGIACOMO, MD, OSCAR P	PHILADELPHIA
DIGIACOMO, MD, PAUL R	LEBANON
DIGIACOMO JR, MD, PHILIP J	MONTGOMERY
DIGILIO, MD, VICTOR A	PHILADELPHIA
DIGIOVANNI, MD, VINCENT J	LUZERNE
DIGREGORIO, MD, GUERINO J	CHESTER
DIIORIO, MD, EMIL J	NORTHAMPTON
DILCHER, MD, ROBERT H	LEHIGH
DILEO, MD, DOMINIC W	FAYETTE
DILEONARDO, MD, MARIO	PHILADELPHIA
DILIBERTO, DO, THOMAS A	DELAWARE
DILL, JANE E	STUDENT
DILLINGER, MD, ELLEN M	ALLEGHENY
DILLON, MD, DANIEL J	ALLEGHENY
DILLON, JOHANNE E	STUDENT
DILLON, DO, MARY C	ALLEGHENY
DILLON, MD, RICHARD L	DELAWARE
DILLON, MD, RICHARD S	MONTGOMERY
DIMAGGIO, MD, OLIVIA T	DELAWARE
DIMAIO, MD, F H PAUL	CLARION
DIMARCO, DO, ANTHONY E	DELAWARE
DIMARCO, DO, LINDA M	ERIE
DIMARCO, DO, LUCIANO A	DAUPHIN
DIMARCO, MD, ROSS F	ALLEGHENY
DIMARINO, MD, ANTHONY J	PHILADELPHIA
DIMASI, DO, ROBERT E	ERIE
DIMAURO, MD, CYNTHIA L	ALLEGHENY
DIMICK, MD, DEAN F	LEHIGH
DIMILILER, MD, ISMAIL	NORTHMBRLAND
DIMITSOPULOS, MD, DIMITRI	ALLEGHENY
DIMOIA, MD, MARGARET M	BUCKS
DIMSDALE, MD, JASON M	ALLEGHENY
DIMUN, MD, MICHAEL F	ALLEGHENY
DINGER, MD, JOHN M	BLAIR
DINICOLA, MD, ARTHUR N	SCHUYLKILL
DINICOLA, MD, ARTURO N	SCHUYLKILL
DINON, MD, LOUIS R	PHILADELPHIA
DINSMORE, MD, HARRY H	JEFFERSON
DINUBILE, MD, NICHOLAS A	PHILADELPHIA
DINULOS, MD, BALTAZAR T	LEBANON
DION, MD, HARRY S	PHILADELPHIA
DIPILLO, MD, MARK A	BERKS
DIPPL, MD, JULIA M	PHILADELPHIA
DIPPOLITO, MD, ANTHONY D	NORTHAMPTON
DIRENZO, MD, DENNIS P	BERKS
DIRIENZO, MD, ENRICO J	BUCKS
DIRNBERGER, DO, THOMAS	SCHUYLKILL
DIROCCO, MD, VINCENT P	PHILADELPHIA
DISALVO, MD, BARBARA A	NORTHAMPTON
DISALVO, MD, EUGENE I	NORTHAMPTON
DISANDRO, MD, DANIEL G	PHILADELPHIA
DISCHMAN, MD, GREGORY D	ALLEGHENY
DISHART, MD, PAUL W	ALLEGHENY
DISILVESTRO, MD, HELEN E	PHILADELPHIA
DISILVESTRO JR, MD, JOHN M A	PHILADELPHIA
DISILVIO, MD, THOMAS V	LACKAWANNA
DISIMONE, MD, RONALD E	LYCOMING
DISSINGER, JENNIFER A	STUDENT
DISTEFANO, MD, BERARDINO	ERIE
DISTEFANO, MD, GRIMALDO C	PHILADELPHIA
DITANO II, MD, ORIENTE	ALLEGHENY
DITLOW JR, MD, RICHARD J	CUMBERLAND
DITMARS, MD, DOUGLAS D	NORTHAMPTON
DITOPPA, DO, LOUIS A	ALLEGHENY
DITTMAN, MD, THOMAS H	LUZERNE
DITTMAR, MD, NYRA M	MONTGOMERY
DITTRICH, DO, RICHARD J	PHILADELPHIA
DITULLIO, MD, NICHOLAS P	STUDENT
DITUNNO JR, MD, JOHN F	PHILADELPHIA

DIVEN, MD, JUDITH C	ALLEGHENY
DIWAN, MD, KANTA	DELAWARE
DIWAN, MD, SATYENDRA K	DELAWARE
DIX, MD, DAVID G	PHILADELPHIA
DIX JR, MD, ROBERT C	UNION
DIXIT, MD, NIRANJAN D	FAYETTE
DIXIT, MD, VAISHALI N	STUDENT
DIXON, MD, ARTHUR S	MONROE
DIXON, MD, GARRETT W	VENANGO
DIXON, MD, HAROLD L	PHILADELPHIA
DIXON, MD, RICHARD H	CENTRE
DIXON, MD, ROBERT E	MIFFLIN/JUNIATA
DIZON, MD, GAUDENCIO S	CARBON
DJERASSI, MD, ISAAC	PHILADELPHIA
DLIN, MD, BARNEY M	PHILADELPHIA
DLUTOWSKI, MD, BERNARD J	PHILADELPHIA
DLUZANSKY, MD, JAMES J	BLAIR
DO, MD, SI V	DAUPHIN
DOAN, PHUONG-ANH T	STUDENT
DOBISH, MD, MARK P	FRANKLIN
DOBKIN, MD, LARRY A	ALLEGHENY
DOBKIN, MD, STEPHEN F	DELAWARE
DOBLER, MD, JAMES C	ALLEGHENY
DOBLER, MD, LEE C	ALLEGHENY
DOBROSKY, MD, JOSEPH D	NORTHAMPTON
DOBROTA, MD, JOHN S	BUCKS
DOBROWOLSKI, MD, ROBERT C	STUDENT
DOCKTOR, MD, JOHN W	YORK
DODD, MD, STEPHEN I	MIFFLIN/JUNIATA
DODDS, MD, H THOMAS	DELAWARE
DODGE, MD, HERBERT C	PHILADELPHIA
DODGE, JESSICA L	STUDENT
DODIA, VISHAL H	STUDENT
DODSON, MD, DONALD L	NORTHAMPTON
DODSON, MD, STEVEN R	NORTHAMPTON
DOE, MD, ROBERT G	LANCASTER
DOEBLER, MD, ROBERT W	ALLEGHENY
DOENECKE, MD, ARTHUR L	LANCASTER
DOERFLER JR, MD, FREDERICK B	ARMSTRONG
DOFT, MD, BERNARD H	ALLEGHENY
DOHERTY, MD, JAMES L	PHILADELPHIA
DOHERTY, MD, JOHN C	STUDENT
DOHERTY, DO, JOHN M	DELAWARE
DOHERTY, MD, JOSEPH C	WESTMORELAND
DOHERTY JR, MD, HENRY J	MONTGOMERY
DOHERTY JR, MD, JOHN H	LACKAWANNA
DOHERTY SR, MD, JOHN H	LACKAWANNA
DOLAN III, MD, JAMES J	CLINTON
DOLAND, MD, CHERYL A	YORK
DOLD, FREDERICK G	STUDENT
DOLENCE, MD, LAURICE A	YORK
DOLFMAN, MD, VICTOR	PHILADELPHIA
DOLINSKAS, MD, CAROL A	PHILADELPHIA
DOLL JR, MD, ROBERT B	LEHIGH
DOLPHIN, MD, JOHN M	PHILADELPHIA
DOLSKY, MD, RICHARD L	MONTGOMERY
DOMAT, MD, IMAD	ALLEGHENY
DOMBKOSKI, MD, RUTH A	DELAWARE
DOMERACKI, MD, FRANK R	MONTGOMERY
DOMERACKI, GARY F	STUDENT
DOMESEK, MD, JAMES M	PHILADELPHIA
DOMINGO, MD, ORVILLE H	DELAWARE
DOMIT, MD, JOHN	WESTMORELAND
DON, SIDNEY H	STUDENT
DONAHOE, MD, MICHAEL T	FRANKLIN
DONAHUE, MD, JOHN R	MONTGOMERY
DONALD, MD, RANITA	PHILADELPHIA
DONALDSON, DO, GORDON R	BERKS
DONALDSON, MD, JAMES B	PHILADELPHIA
DONALDSON, MD, WILLIAM F	ALLEGHENY
DONALDSON III, MD, WILLIAM F	ALLEGHENY
DONAN, MD, ANDERSON W	MERCER
DONATELLI, MD, JOHN M	ALLEGHENY
DONATO, DO, ROBERT A	LYCOMING
DONCASTER, MD, RICHARD M	WESTMORELAND
DONDE, MD, DILIP M	CAMBRIA
DONDE, MD, MRUNALINI D	CAMBRIA
DONEKER, MD, THOMAS G	NORTHAMPTON
DONER, DO, IVAN A	PHILADELPHIA
DONLEY JR, MD, CHARLES M	ALLEGHENY
DONNELLY, MD, BRIAN W	ALLEGHENY
DONNER, MD, WILLIAM T	MONTGOMERY
DONOFRIO, MD, ROBERT J	ALLEGHENY
DONOGHUE, MD, GLENDA D	PHILADELPHIA
DONOHUE, MD, BRYAN C	WASHINGTON
DONOVAN, MD, ALTHEA A	CHESTER
DONOVAN, MD, BYRON L	WESTMORELAND
DONOVAN, MD, FRANCIS C	ALLEGHENY
DONOVAN, MD, MARY E	PHILADELPHIA
DONOVAN, MD, ROBERT J	ALLEGHENY
DONOVAN, MD, ROBERT J	LACKAWANNA
DONOVAN, MD, ROBERT S	BERKS
DONROVICH, MD, PAUL J	CAMBRIA
DOO, MD, GERALD K	ADAMS
DOOKHAN, MD, DIANNE B	PHILADELPHIA
DOOLEY, MD, JOHN M	YORK
DOOLEY, MD, THOMAS W	BERKS
DORAZIO, MD, DOMINICK J	LANCASTER
DOREY, MD, FRED O	PHILADELPHIA
DORF, DO, STEVEN N	LANCASTER
DORFMAN, MD, ALAN M	MONTGOMERY
DORFMAN, MD, MICHAEL	PHILADELPHIA
DORFMAN, MD, MURRAY L	DELAWARE
DORIAN, MD, ALAN L	MONTGOMERY
DORION, MD, ROBERT P	MONTOUR
DORKO, MD, CARL J	DAUPHIN
DORMAN, MD, GORDON	PHILADELPHIA
DORMAN, MD, SANFORD A	NORTHAMPTON
DORMANS, MD, JOHN P	PHILADELPHIA
DORNENBURG, MD, JAMES R	ALLEGHENY
DORNFEST, MD, FRANKLYN D	BRADFORD
DORNSTEIN, MD, PERRY I	MONTGOMERY
DORO, MD, LOUIS C	WASHINGTON
DORRELL, MD, SEAN G	CHESTER
DORSCH, MD, CAROLE A	YORK
DORSCH, VERONICA C	STUDENT
DORSCH JR, MD, RAYMOND M	LEBANON
DORSEY, DENISE M	STUDENT
DORSEY, MD, JAMES T	LEHIGH
DORSHIMER, MD, GARY W	PHILADELPHIA
DORVAL, MD, JANE	LEHIGH
DORVILLE, MD, FABIO L	NORTHAMPTON
DORWART, MD, BONNIE B	PHILADELPHIA
DOSHI, MD, KIRTI K	PHILADELPHIA
DOSHI, MD, NALINI N	ALLEGHENY
DOSHI, MD, NARENDRA S	ALLEGHENY
DOSTAL, MD, JULIE A	LUZERNE
DOTO JR, MD, JOSEPH B	NORTHAMPTON
DOTSEY, MD, MICHAEL T	CLEARFIELD
DOTTERER, MD, CHRISTINE S	NORTHMBRLAND
DOTTOR, MD, ALBINKA J	LEHIGH
DOTTS, EXEC SEC, CAROL A	CHESTER
DOUDS, MD, HOWARD N	ALLEGHENY
DOUGHERTY, MD, CATHLEEN	MONTGOMERY
DOUGHERTY, ELIZABETH A	STUDENT
DOUGHERTY, MD, MALVIN J	PHILADELPHIA
DOUGHERTY, MD, MARY C	MERCER
DOUGHERTY, MD, MICHAEL J	BEAVER
DOUGHERTY, MD, RALPH N	ALLEGHENY
DOUGHERTY, MD, TIMOTHY J	PHILADELPHIA
DOUGHERTY III, DO, JOHN E	DAUPHIN
DOUGLAS, MD, BARBARA S	STUDENT
DOUGLAS, MD, DONALD D	UNION
DOUGLAS, JAMES E	STUDENT
DOUGLAS, MD, RICHARD A	ALLEGHENY
DOUGLAS, MD, STEVEN D	PHILADELPHIA
DOUGLASS, MD, PAUL H	YORK
DOUGLASS JR, MD, WILLIAM T	DAUPHIN
DOUPE, MD, DAVID W	ERIE
DOVNARSKY, MD, JAMES H	PHILADELPHIA
DOWDELL, MD, PAUL J	MERCER
DOWLING, MD, JOHN J	PHILADELPHIA
DOWLING, MD, KEITH J	DAUPHIN
DOWLING, ROBERT F	STUDENT
DOWLUT, MD, MOHAMMAD N	BLAIR
DOWNER, MD, WILLIAM R	ALLEGHENY
DOWNES, MD, JOHN J	PHILADELPHIA
DOWNING, MD, MICHAEL J	PHILADELPHIA
DOWNING, MD, TIMOTHY M	CRAWFORD
DOWNS, DO, CAROLYN R	BUCKS
DOWNS JR, LEVI S	STUDENT
DOYLE, MD, ALFRED P	ALLEGHENY
DOYLE, DO, DAVID A	LEHIGH
DOYLE, MD, FAYE R	CHESTER
DOYLE, MD, HARRY A	PHILADELPHIA
DOYLE, MD, HOWARD R	ALLEGHENY
DOYLE, MD, JOHN J	ALLEGHENY
DOYLE, MD, RUSSELL G	CHESTER
DOYLE, THOMAS J	STUDENT
DOYLE, MD, TIMOTHY G	DAUPHIN
DRACOS, MD, FRANK J	MONROE
DRAGANOSKY, MD, EUGENE A	BUCKS
DRAGO, MD, JOSEPH R	NORTHAMPTON
DRAGUN, MD, JOANNE B	VENANGO
DRAIN, MD, RANDALL T	PHILADELPHIA
DRANOV, MD, JONATHAN	CENTRE
DRAPER, MD, NELLE E	PHILADELPHIA
DRAPIEWSKI, MD, JOHN F	LUZERNE
DRASS, MD, MICHAEL J	YORK
DRATCH, MD, ADAM D	MONTGOMERY
DRATCH, MD, MICHAEL B	PHILADELPHIA
DRATLER, MD, M BRUCE	CRAWFORD
DRATMAN, MD, CATHY K	PHILADELPHIA
DREER, MD, AARON M	PHILADELPHIA
DREHER, MD, ROBERT H	NORTHAMPTON
DREIBELBIS, MD, WILLIAM H	CENTRE
DREIFUS, MD, LEONARD S	PHILADELPHIA
DRENNEN, DO, BRADLEY R	CAMBRIA
DRENNEN JR, MD, JAMES K	BUTLER
DRESSEL JR, MD, CHRISTOPHER J	LACKAWANNA
DREW, MD, FRANCES L	ALLEGHENY
DREZNER, MD, MALCOLM E	BUCKS
DRINKER, MD, HENRY M	PHILADELPHIA
DRISCOLL, MD, GENEVRA Z	MONTGOMERY
DROOGAN, DO, CHRISTOPHER J	DELAWARE
DROZDIAK, MD, RUSSELL A	INDIANA
DRUBETSKY, MD, NORMAN	PHILADELPHIA
DRUCKMAN, MD, STEPHEN M	LEBANON
DRUFFNER JR, MD, LEWIS C	LACKAWANNA
DRUMMOND, MD, DENIS S	PHILADELPHIA
DRY, MD, FREDERICK A	LEHIGH
DSILVA, MD, HENRY I	BUCKS
DUA, MD, RITA	PHILADELPHIA
DUA, MD, RUP K	ALLEGHENY
DUARTE, MD, CESAR A	ALLEGHENY
DUBEL, MD, GREGORY J	PHILADELPHIA
DUBEY, MD, SAROJ K	ERIE
DUBIN, MD, WILLIAM R	PHILADELPHIA
DUBLIN, MD, GEORGE J	PHILADELPHIA
DUBNER, MD, PAUL F	ALLEGHENY
DUBOV, MD, WAYNE E	LEHIGH
DUBROVSKY, MD, OLGA	ALLEGHENY
DUBRY, MD, SETH M	ALLEGHENY
DUCA, MD, MARK A	STUDENT
DUCA, MD, PETER R	PHILADELPHIA
DUCKETT, MD, JAMES E	DELAWARE
DUCKETT JR, MD, JOHN W	PHILADELPHIA
DUCKO, CHRISTOPHER T	STUDENT
DUDA, MD, ANDREW M	BERKS
DUDA, MD, JOHN R	ERIE
DUDECK, MD, CARL R	BUTLER
DUDEK, MD, ARKADIUSZ Z	DAUPHIN
DUDENHOEFER, MD, CHRISTIAN P	ERIE
DUDENHOEFER, MD, FREDERICK J	ERIE
DUDENHOEFER, MD, KATHLEEN M	ERIE
DUDLEY, MD, ROBERT W	PHILADELPHIA
DUDZINSKI, DO, JOHN E	ERIE
DUE, MD, CHRISTOPHER F	YORK
DUER, MD, NATHAN B	GREENE
DUERKSEN, MD, ROGER L	ALLEGHENY
DUFFIELD, MD, THOMAS E	BUCKS
DUFFY, MD, CHERYL A	MERCER
DUFFY, MD, CLYDE F	ALLEGHENY
DUFFY, MD, RUTH E	CHESTER
DUFFY, MD, SCOTT S	BERKS
DUFFY, MD, TERENCE F	LUZERNE
DUGAN, MD, CHARLES T	WESTMORELAND
DUGAN, MD, THOMAS M	ERIE
DUGAN JR, MD, THOMAS M	BEAVER
DUGGAN, MD, JAMES H	ALLEGHENY
DUGGAN JR, MD, FRANCIS J	DAUPHIN
DUGGER, MD, DOROTHY E	PHILADELPHIA
DUHAIME, MD, ANN-CHRISTINE	PHILADELPHIA
DUHL, MD, ADAM J	PHILADELPHIA
DUKE II, MD, LEE M	LANCASTER
DUKE III, MD, BRUCE E	CAMBRIA
DUKER, MD, DANIEL G	ALLEGHENY
DULA, MD, DAVID J	MONTOUR
DULABON, MD, DAVID A	ERIE
DULL, MD, JAMES A	WESTMORELAND
DUMARAN, MD, DELFA G	MONTGOMERY
DUMAS, MD, PETER A	PHILADELPHIA
DUMPE, MD, KEVIN C	BEAVER
DUMPE, MD, PAMELA M	BEAVER
DUNAGIN, MD, WILLIAM G	VENANGO
DUNAY, DO, DARLENE A M	LACKAWANNA
DUNCAN, MD, CARL R	YORK
DUNCAN, MD, JAMES R	ALLEGHENY
DUNCAN, MD, RALPH E	YORK
DUNCAN, MD, THEODORE G	PHILADELPHIA
DUNCOMBE, MD, MICHAEL P	ERIE
DUNDEE, MD, DAVID T	PHILADELPHIA
DUNDORE JR, MD, WILLIAM C	MERCER
DUNHAM, DO, DOUGLAS A	ALLEGHENY
DUNKELBERGER, MD, JOHN A	CENTRE
DUNKLE, MD, DAVID B	DAUPHIN
DUNN, MD, DAVID D	ERIE
DUNN, MD, GEOFFREY P	ERIE
DUNN, MD, JAMES C	PHILADELPHIA
DUNN, MD, JEANETTE C	ALLEGHENY
DUNN, MD, JEROME	LEHIGH
DUNN, MD, JOSEPH P	VENANGO
DUNN, MD, LINDA K	MONTGOMERY
DUNN, DO, LORI	DAUPHIN
DUNN, MD, PHILIP F	HUNTINGDON
DUNNE, MD, GAY D	CENTRE
DUNNE, MD, JAMES H	CENTRE
DUNNING, MD, E RUTH	MONROE
DUNSKY, MD, ELIOT H	PHILADELPHIA
DUPLER, MD, DONALD A	PHILADELPHIA
DUPONT, DO, DANIEL C	DELAWARE
DUPONT JR, MD, PHILIP J	CLEARFIELD
DUPREE, MD, BETH B	BUCKS
DUPREY, MD, JAMES G	LANCASTER
DUQUE DE ESTRADA, MD, WALTER B	ALLEGHENY
DURAKO, DO, ROBERT A	MONTOUR
DURBACK, MD, MARK A	NORTHAMPTON
DURBECK, MD, DONALD C	DAUPHIN
DURBIN, MD, DENNIS R	PHILADELPHIA
DURGIN, MD, BERNICE E	CENTRE
DURHAM, SUSAN R	STUDENT
DURISEK, MD, GEORGE S	DAUPHIN
DURKAN JR, MD, GERALD	ALLEGHENY
DURKIN, MD, DAVID J	CENTRE
DURKIN, DO, JANE E	LUZERNE
DURKIN, MD, MARTIN J	MONTGOMERY
DURKIN, MD, MAUREEN L	ADAMS
DURKIN, MD, RAYMOND A	LEHIGH
DURNING, MD, ROBERT P	ALLEGHENY
DUROCHER, MD, JOHN R	PHILADELPHIA
DURRWACHTER, MD, KENNETH R	LYCOMING
DURRWACHTER, MD, ROBERT J	LYCOMING
DUSENBERRY, MD, SARAH J	BEAVER
DUTHINH, MD, VUONG	BUCKS
DUTT, MD, RINKU M	ALLEGHENY
DUTTA, MD, TARIT K	ALLEGHENY
DUTTON, MD, TIMOTHY E	STUDENT
DVORCHAK, MD, MATTHEW J	CAMBRIA
DVORIN, MD, DONALD J	PHILADELPHIA
DVORKIN, MD, DANIEL	CHESTER
DWECK, MD, MONICA M	LEHIGH
DWORETZ, MD, APRIL R	ALLEGHENY
DWORKIN, DO, GERALD E	PHILADELPHIA
DWYER, MD, JOHN H	ALLEGHENY
DY, MD, GEORGE R	TIOGA
DYCKMAN, MD, SHARON	BUCKS
DYE, MD, ROBERT E	DAUPHIN
DYKYJ JR, MD, ROMAN	PHILADELPHIA
DYNAN, MD, JAMES E	MONTGOMERY
DYREYES, MD, ROBERTO R	LEBANON
DZERA, MD, OLEH	TIOGA
DZIALOWSKI, MD, KENNETH J	WESTMORELAND
DZWONCZYK, MD, THOMAS D	LANCASTER
DZWONCZYK JR, MD, JOHN	PHILADELPHIA

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EAGEN, MD, JEREMIAH W	LACKAWANNA
EAGEN, KATHRYN A	STUDENT
EAGER, MD, J MICHAEL	BERKS
EAGLE, MD, PERRY A	YORK
EAKINS, MD, JAMES S	PHILADELPHIA
EARLE, MD, LINDA A	PHILADELPHIA
EARLE, MD, MARTIN F	ALLEGHENY
EARLE-BROWN, MD, JOYLEEN E	PHILADELPHIA
EARLY, MD, CALVIN B	FRANKLIN
EARLY JR, MD, ROBERT F	BERKS
EARLY SR, MD, ROBERT F	LEBANON
EARNEST, MD, TAMAR D	LEHIGH
EASLER, MD, RICHARD E	ALLEGHENY
EASTMAN, MD, LAURA B	ALLEGHENY
EATER JR, MD, CHARLES L	MIFFLIN/JUNIATA
EATON, AUDREY M	STUDENT
EATON, MD, DAVID A	NORTHAMPTON
EATON, MD, EDWARD H	DAUPHIN
EATON, MD, ELIZABETH A	ALLEGHENY
EATON, MD, JEFFREY G	CENTRE
EBBA, MD, CELSUS I	DELAWARE
EBBERT, MD, COLLEEN K	ALLEGHENY
EBERHART, MD, JOSEPH C	BUCKS
EBERLE, MD, ROBERT L	MONTGOMERY
EBERLY, MD, DAVID E	DELAWARE
EBERSOLE, MD, THOMAS M	BERKS
EBERT, MD, KARL H	PHILADELPHIA
EBERZ, MD, DENNIS A	ALLEGHENY
EBY, MD, CARL E	ERIE
ECHENBERG, MD, ROBERT J	NORTHAMPTON
ECHIKSON, MD, EDWARD H	MONTGOMERY
ECKBERG, MD, JOHN J	ERIE
ECKEL, MD, TIMOTHY B	COLUMBIA
ECKELS, DO, DENNIS L	CAMBRIA
ECKENRODE, MD, JOSEPH L	LANCASTER
ECKER, MD, ANDREW M	MONTGOMERY
ECKER, MD, MALCOLM L	PHILADELPHIA
ECKER JR, MD, HERBERT A	LYCOMING
ECKER SR, MD, HERBERT A	LYCOMING
ECKERT, MD, ROBERT T	BUTLER
ECKROTH, MD, RICHARD N	LEBANON
EDDINGER, MD, LEO C	LEHIGH
EDDY, MICHAEL J	STUDENT
EDELMAN, MD, JONATHAN M	PHILADELPHIA
EDELMANN, MD, CHRISTINE A	ALLEGHENY
EDELSTEIN, MD, ABE J	CAMBRIA
EDELSTEIN, MD, JOEL K	PHILADELPHIA
EDELSTEIN, MD, NORMAN L	ALLEGHENY
EDER JR, MD, GEORGE E	YORK
EDGAR, MD, KENNETH A	DAUPHIN
EDGE, MD, FRED C	FAYETTE
EDGELL, MD, PENNE H	BLAIR
EDINGTON, MD, JOHN M	PHILADELPHIA
EDMISTON, MD, ROBERT B	DAUPHIN
EDMOND-COOPER, MD, DONNA V	PHILADELPHIA
EDMUNDOWICZ, MD, ALPHONSE C	DAUPHIN
EDMUNDS, MD, ELIZABETH H	BERKS
EDNIE, MD, BRENT	ALLEGHENY
EDWARDS, MD, ALAN E	BEAVER
EDWARDS, MD, ANITA	ALLEGHENY
EDWARDS, MD, ANTONIO D	YORK
EDWARDS, MD, GEORGE E	DAUPHIN
EDWARDS, MD, MARY D	ALLEGHENY
EDWARDS, MD, WILLIAM M	ALLEGHENY
EDWARDS, MD, WILLIAM P	VENANGO
EELKEMA, MD, ELIZABETH A	ALLEGHENY
EFFAT, MD, MAHMOUD K	CHESTER
EFFINGER-KASSOW, MD, ELLIN B	PHILADELPHIA
EGGLER, MD, BETSEY A	CENTRE
EGLICK, MD, PAUL G	PHILADELPHIA
EGOVILLE, MD, CHARLES R	PHILADELPHIA
EHGARTNER, DO, GREG R	DAUPHIN
EHLY, MD, GEORGE W	CUMBERLAND
EHRENBERG, DO, ERIC E	BEAVER
EHRLICH, MD, CLIFFORD L	MONTGOMERY
EHRLICH, MD, FRANK	PHILADELPHIA
EHRLICH, MD, GEORGE E	PHILADELPHIA
EHRLICH, MD, LEONARD D	MONTGOMERY
EHRMAN, MD, WALTER J	DAUPHIN
EHYA, MD, HORMOZ	PHILADELPHIA
EIBLING, MD, DAVID E	ALLEGHENY
EICHELBERGER, MD, DWIGHT O	LANCASTER
EICHENLAUB, MD, JOHN J	LANCASTER
EICHER, MD, PEGGY S	PHILADELPHIA
EICHER, MD, WENDELL P	BUCKS
EICHLER, MD, GEORGE R	NORTHAMPTON
EICHMILLER, MD, JOHN P	ALLEGHENY
EICHNER, MD, LAMBERT G	DELAWARE
EILER, MD, WILLIAM A	ALLEGHENY
EINHORN, MD, KENNETH H	MONTGOMERY
EISEN, MD, CAROLE L	DELAWARE
EISEN, MD, HOWARD B	ALLEGHENY
EISENBEIS JR, MD, CARL H	ALLEGHENY
EISENBERG, MD, FLOYD P	MONTGOMERY
EISENBERG, MD, RICHARD B	ERIE
EISENHARDT, DO, BRUCE T	NORTHAMPTON
EISENHOWER, MD, EDWARD A	LANCASTER
EISENHOWER-TURNER, MD, EDITH S	DELAWARE
EISENSTADT, MD, NORMAN	PHILADELPHIA
EISMAN, MD, SYLVAN H	PHILADELPHIA
EISNER, MD, ABRAHAM G	LACKAWANNA
EISNER, MD, JOEL W	CHESTER
EISNER, MD, STEVEN B	LACKAWANNA
EISTER, MD, RONALD N	LYCOMING
EISTER, EXEC DIR, LOUIS L	LEHIGH

EKBERG, MD, NORMAN L	MONTOUR
EL MASRY, MD, WAGUIH S	ALLEGHENY
EL-ATTRACHE, MD, MAMDOUH F	WESTMORELAND
EL-ATTRACHE, MD, SELIM	WESTMORELAND
EL-AWAR, MD, MUNIR Y	ALLEGHENY
EL-BORNO, MD, BASSAM M A	LANCASTER
EL-HILLAL, MD, MOHAMMAD F	WESTMORELAND
EL-MANSOURY, MD, JEYLAN A	PHILADELPHIA
ELATTAR, MD, ANAS A	ALLEGHENY
ELBASH, MD, ABDELAZIZ A R	MCKEAN
ELCOCK, MD, CLAUDIUS A	PHILADELPHIA
ELDAIEF, MD, DAISY S	MONTGOMERY
ELDER, MD, E GLENN	NORTHAMPTON
ELDER, MD, JAY E	JEFFERSON
ELEFANT, MD, HOWARD L	PHILADELPHIA
ELENITSAS, MD, ROSALIE	PHILADELPHIA
ELES, DO, GUSTAV R	ALLEGHENY
ELFMAN, MD, LOUIS K	PHILADELPHIA
ELIA, MD, EUGENE A	DELAWARE
ELIADES, MD, WILLIAM	PHILADELPHIA
ELIAS, MD, AFIF	ALLEGHENY
ELIAS, MD, FARID J	WESTMORELAND
ELIAS, MD, GARTH A	ARMSTRONG
ELIAS, MD, STANTON B	ALLEGHENY
ELIAS, MD, ZEV	LEHIGH
ELKIN, DO, RICHARD J	LANCASTER
ELKIN, MD, RODNEY M	DELAWARE
ELKOUSY, MD, MOHAMMED A	PHILADELPHIA
ELLEN, MD, STEPHEN J	PHILADELPHIA
ELLENBERGER, MD, PAMELA M	BERKS
ELLENBERGER JR, MD, CARL	LEBANON
ELLER, MD, ANDREW W	ALLEGHENY
ELLIS, MD, CHRISTINA E	CHESTER
ELLIS, MD, DAVID J	DELAWARE
ELLIS, MD, DAVID M	MONTGOMERY
ELLIS, MD, DAVID W	LEBANON
ELLIS, MD, HERMAN M	PHILADELPHIA
ELLIS, MD, KATHRYN K	WESTMORELAND
ELLIS, MD, LAWRENCE D	ALLEGHENY
ELLIS, DO, LOUIS D	SCHUYLKILL
ELLIS, MELISSA P	STUDENT
ELLIS, MD, PETER G	ALLEGHENY
ELLIS, MD, RICHARD A	PHILADELPHIA
ELLIS, EDD EXEC DIR, U BERKLEY	MONTGOMERY
ELLIS IV, MD, JOHN H	LUZERNE
ELLIS JR, MD, LEANDER T	PHILADELPHIA
ELLISON, MD, JAMES H	YORK
ELLISON, MD, JULIUS	PHILADELPHIA
ELLISON, MD, MARYJANE	ALLEGHENY
ELLISON, MD, NEIL M	MONTOUR
ELLISON, MD, NORIG	MONTGOMERY
ELLISON JR, MD, RICHARD T	MONTGOMERY
ELMALEH, MD, MIRIAM K	PHILADELPHIA
ELNOUR, MD, MOHAMED F	DAUPHIN
ELSAWY, MD, MAGDY M	ALLEGHENY
ELSNER, MD, CYNTHIA A	DAUPHIN
ELTON, MD, SCOTT W	STUDENT
ELVIR, MD, RAMON	WARREN
ELYADERANI, MD, MORTEZA K	BEAVER
EMAMI, ELIZABETH R	STUDENT
EMANUEL, MD, ABRAHAM	BEAVER
EMANUELSON, MD, RICHARD G	LACKAWANNA
EMERICK, GEORGE J	STUDENT
EMERSON, MD, JOHN A	VENANGO
EMERY, MD, ROBERT C	NORTHAMPTON
EMIG, MD, ERIC W	PHILADELPHIA
EMKEY, MD, KENNETH D	BERKS
EMKEY, MD, RONALD D	BERKS
EMMOLO, MD, ALFONSE A	VENANGO
EMPER, MD, WILLIAM D	MONTGOMERY
ENANY, MD, ALBERT K	FAYETTE
ENCKE, MD, TED K	ALLEGHENY
ENDO, MD, RONALD N	BUCKS
ENDRES, MD, JAY E	WARREN
ENDRES, MD, WARREN H	LEHIGH
ENER, MD, RASIH A	DAUPHIN
ENG, MD, CATHY	STUDENT
ENG, MD, RENE S M	PHILADELPHIA
ENG, MD, RICARDO	PHILADELPHIA
ENGEL, MD, EDWARD E	ERIE
ENGEL, MD, EILEEN G	ERIE
ENGEL, MD, GREGORY S	ERIE
ENGEL, MD, ROBERT	LUZERNE
ENGLAND, MD, MICHAEL V	BLAIR
ENGLE, MD, CAROLYN P	BEAVER
ENGLE, MD, DAVID J	ALLEGHENY
ENGLE, MD, EUGENE K	LANCASTER
ENGLE, MD, HAROLD H	LEBANON
ENGLE, MD, JOSEPH H	FRANKLIN
ENGLISH, MD, DENNIS H	ALLEGHENY
ENGLISH, MD, JAMES B	BLAIR
ENGLISH, MD, JOSEPH G	LYCOMING
ENGLISH, MD, RICHARD B	LUZERNE
ENGLISH, ROBERT F	STUDENT
ENGLISH, MD, ROBERT S	FAYETTE
ENGLISH JR, MD, WALTER E	CLINTON
ENGSTROM, MD, PAUL F	PHILADELPHIA
ENNIS, MD, MICHAEL F	ALLEGHENY
ENNIS, MD, PETER D	PHILADELPHIA
ENRIQUEZ, MD, DANILO L	ALLEGHENY
ENTERLINE, MD, HORATIO T	PHILADELPHIA
ENTWISTLE, MD, NELSON L	DAUPHIN
ENZMAN, DO, PATRICIA M	LEHIGH
EPERJESSY, MD, ERNEST Z	CAMBRIA
EPISCOPIO, MD, JOSEPH V	NORTHAMPTON
EPPINGER, MD, MARY ANN	ALLEGHENY
EPPLEY, MD, MATTHEW J	PHILADELPHIA
EPSTEIN, MD, ALAN L	PHILADELPHIA
EPSTEIN, MD, HERMAN	PHILADELPHIA
EPSTEIN, MD, ISADORE S	PHILADELPHIA
EPSTEIN, MD, PAUL E	PHILADELPHIA
EPSTEIN, MD, ROBERT E	PHILADELPHIA
EPSTEIN, MD, SCOTT K	PHILADELPHIA
ERB, MD, KATHLEEN M	ERIE
ERHARD, MD, MICHAEL J	PHILADELPHIA
ERICKSEN, MD, JEFFERY J	DELAWARE
ERICKSON, MD, ELMER W	ALLEGHENY
ERKES, MD, NEAL	PHILADELPHIA
ERKI, MD, LENKE	STUDENT
ERLICHMAN, MD, I FULTON	BUCKS
ERLICHMAN, DO, KATHERINE E	BEDFORD
ERMOLD, MD, DONALD R	BERKS
ERNST, MD, BRETT B	DAUPHIN
ERNSTOFF, MD, BRIAN M	ALLEGHENY
ERSNER, MD, ARTHUR R	MONTGOMERY
ERSOZ, MD, CLARA J	ALLEGHENY
ERTEL, MD, D GREGORY	BERKS
ERUKHIMOV, MD, JEFFREY A	ALLEGHENY
ERVIN, MD, LAWRENCE M	BLAIR
ERWIN, MD, HENRY K	NORTHAMPTON
ERWIN, MD, KATE M	ALLEGHENY
ERWIN, MD, PATRICK J	COLUMBIA
ERZURUM, MD, SERHAT	LAWRENCE
ESAA, MD, DURRIYA S	LYCOMING
ESAA, MD, SHABBIR A	LYCOMING
ESBENSHADE II, MD, JOHN H	LANCASTER
ESCANDON, MD, PEDRO J	PHILADELPHIA
ESCARO, MD, DANILO U	YORK
ESCHBACH, MD, EUGENIE M	BUCKS
ESCHELMAN, MD, DAVID J	PHILADELPHIA
ESCOVITZ, MD, GERALD H	PHILADELPHIA
ESCOWITZ, HAL E	STUDENT
ESH, MD, KIMBERLY J	YORK
ESHBACH, MD, TED B	DAUPHIN
ESHELMAN, DO, JOSEPH K	ALLEGHENY
ESHELMAN JR, MD, GUY R	LANCASTER
ESHLEMAN, MD, D ROHRER	LANCASTER
ESHLEMAN, JEFFREY S	STUDENT
ESHLEMAN, MD, JOHN D	LANCASTER
ESHLEMAN, MD, S KENDRICK	LANCASTER
ESKANDARI, MD, MARK K	ALLEGHENY
ESKENDRI, MD, NASSER	BEAVER
ESKIN, MD, BERNARD A	PHILADELPHIA
ESKIN, MD, DAVID J	MONTGOMERY
ESKREIS, MD, BEVERLY D	MONTGOMERY
ESKRIDGE, MD, TIMOTHY H	YORK
ESLER JR, MD, JAMES W	LEHIGH
ESPER, DO, ERIK O	ERIE
ESPER, DO, GARY F	ERIE
ESPER, DO, JEFFREY J	ERIE
ESPER, DO, RONALD A	ERIE
ESPER, DO, STEPHANY F	ERIE
ESPER, DO, WILLIAM A	ERIE
ESPER JR, RICHARD T	STUDENT
ESPOSITO, MD, FRANCIS A	ALLEGHENY
ESPOSITO, MD, JOHN C	DELAWARE
ESPOSITO, MD, JOSEPH P	DAUPHIN
ESQUENAZI, MD, ALBERTO	PHILADELPHIA
ESSIG, MD, MICHAEL J	ALLEGHENY
ESTOLANO, MD, MARIO G	ALLEGHENY
ESTONILO, MD, RODRIGO M	CHESTER
ESTRADA, MD, FERNANDO P	NORTHAMPTON
ESTRIN, MD, EDWARD H	BEAVER
ETIENNE, MD, ANNEMARIE N	YORK
ETNOYER, MD, JOHN J	LANCASTER
ETTENGER, MD, ALLEN B	HUNTINGDON
ETTENGER, MD, MORRIS S	PHILADELPHIA
ETTER, MARK D	STUDENT
ETTER, MD, RUSSEL H	YORK
ETTINGER, MD, JEFFREY B	PHILADELPHIA
ETTLINGER, MD, ROBERT A	DAUPHIN
ETZEL, MD, KATHLEEN D	ALLEGHENY
EUBANKS, MARCUS J	STUDENT
EULAU, MD, STEPHEN M	PHILADELPHIA
EULIANO JR, MD, JOHN J	ERIE
EULIANO SR, MD, JOHN J	ERIE
EVANGELISTA, MD, JESUS S	WASHINGTON
EVANGELISTA, MD, SIMPLICIO E	MONTGOMERY
EVANGELISTO, AMY M	STUDENT
EVANKOVICH, MD, MICHAEL R	DAUPHIN
EVANS, MD, AUDREY E	PHILADELPHIA
EVANS, MD, CHARLES M	LANCASTER
EVANS, MD, CYNTHIA K	ALLEGHENY
EVANS, MD, DAVID B	CUMBERLAND
EVANS, MD, DAVID J	DAUPHIN
EVANS, MD, DAVID M	CAMBRIA
EVANS, MD, DONALD E	ALLEGHENY
EVANS, MD, HAYDEN O	MONTGOMERY
EVANS, MD, HILARY	CAMBRIA
EVANS, MD, JAMES F	MONTOUR
EVANS, MD, JOHN B	MONTGOMERY
EVANS, DO, JOHN C	CENTRE
EVANS, MD, JOHN J	CARBON
EVANS, MD, JONATHAN L	BUTLER
EVANS, JOSEPH B	STUDENT
EVANS, MD, JOSEPH B	PHILADELPHIA
EVANS, MD, ROBERT L	YORK
EVANS, MD, STEVEN	ALLEGHENY
EVANS, MD, TERRY L	WESTMORELAND
EVANS, MD, THOMAS M	ALLEGHENY
EVANS, MD, WILLIAM G	INDIANA
EVANS, EXEC SEC, ROBERT W	DAUPHIN
EVARTS, MD, C MCCOLLISTER	DAUPHIN
EVERETT, MD, KRISTIN M	STUDENT
EVERETT, MD, WILLIAM G	ALLEGHENY
EVERHART, MD, CHARLES W	MIFFLIN/JUNIATA
EVERHART, MD, WILSON C	DAUPHIN
EVERITT, MD, DANIEL E	PHILADELPHIA
EVERS, MD, KATHRYN A	PHILADELPHIA
EVRARD, MD, HELEN M	UNION
EVRON, MD, WAYNE A	ALLEGHENY
EWALD, MD, JOHN L	FAYETTE
EWEDEMI, OLUFUNKE O	STUDENT
EWING, MD, AGNEW R	CHESTER
EWING, MD, CHARLES H	MONTGOMERY
EWING, MD, JAMES H	PHILADELPHIA
EWING, MD, MADELEINE O	PHILADELPHIA
EXLEY, MD, WILLIAM B	NORTHAMPTON
EYERLY, MD, ROBERT C	MONTOUR
EYLER, MD, J ALBERT	BEDFORD
EYLER, MD, PAUL W	LANCASTER
EYVAZZADEH, MD, CAMILLE	NORTHAMPTON

F

FABENS, MD, ELIZABETH L	PHILADELPHIA
FABER, MD, KALMAN	PHILADELPHIA
FABIANI, MD, JOSEPH A	PHILADELPHIA
FABINYI, MD, GEZA T	BLAIR
FABIO, MD, MARY B	PHILADELPHIA
FACCENDA, MD, DEBORAH R	BUCKS
FACKLER, MD, EMERSON F	DAUPHIN
FACKLER, ERIC G	STUDENT
FACKOVEC, MD, MICHAEL	ALLEGHENY
FADDEN, MD, ROBERT J	BEAVER
FAGAN, DO, LINDA R	PHILADELPHIA
FAGELMAN, MD, KERRY M	DAUPHIN
FAGER, MD, JOSEPH S	DAUPHIN
FAGER, MD, SAMUEL S	PHILADELPHIA
FAGERBURG, MD, RODGER E	LACKAWANNA
FAGIOLETTI, MD, ROBERT J	WASHINGTON
FAHMY, MD, ANDREW	PHILADELPHIA
FAHMY, MD, ANTHONY N	WESTMORELAND
FAHMY, MD, WASFY F	CHESTER
FAIL, MD, PETER S	PHILADELPHIA
FAILLA, MD, JACK P	ALLEGHENY
FAIRBROTHER, MD, MAUREEN E	DAUPHIN
FAIRBROTHER, MD, PAUL F	DAUPHIN
FAIRFIELD, MD, JAMES C	MONTGOMERY
FAIRWEATHER, MD, JACK L	UNION
FAITH, DONALD J	STUDENT
FAKHRAEE, MD, MICHAEL S	PHILADELPHIA
FALANGA, MD, NATALE J	MONROE
FALASCA, DO, THOMAS D	ERIE
FALCO, MD, FRANK J E	MONTGOMERY
FALCON, RONALD W	STUDENT
FALCON JR, MD, JOSEPH R	ALLEGHENY
FALCONE, MD, DOMENICO	LEHIGH
FALCONE, MD, PHILIP M	BERKS
FALK, MD, ARTHUR E	MONTGOMERY
FALK, MD, EDWARD C	MERCER
FALK JR, MD, ROBERT B	LANCASTER
FALKER, MD, JOHN M	MONTGOMERY
FALL, MD, MICHAEL H	BLAIR
FALLAHNEJAD, MD, MANOUCHER	PHILADELPHIA
FALLERT, MD, MICHAEL A	ALLEGHENY
FALLON III, MD, EDWARD C	BERKS
FALOR, MD, STANLEY E L	GREENE
FALUDI, MD, GEORGINA	PHILADELPHIA
FAN, MD, YOUNG C	VENANGO
FANELLI, DO, ANDREW T	BUCKS
FANELLI, MD, CLAUDE	DAUPHIN
FANG, MD, JOHN Y	MONTGOMERY
FANG, MD, PETER J W	FRANKLIN
FANNING, DO, JOHN M	DELAWARE
FANNING, DO, ROBERT J	PHILADELPHIA
FARAGALLA, MD, RAMSES I	FRANKLIN
FARAH, MD, NAGUIB H	LEBANON
FARAH, MD, TONY G	ALLEGHENY
FARALLI, MD, VICTOR J	LEBANON
FARANO, MD, PETER J	PHILADELPHIA
FARB, MD, STANLEY N	MONTGOMERY
FARBER, MD, ABIGAIL F	PHILADELPHIA
FARBER, MD, DAVID N	BERKS
FARBER, MD, EMANUEL P	PHILADELPHIA
FARBER, MD, ERIC B	BERKS
FARBER, MD, HAROLD F	PHILADELPHIA
FARBER, MD, HAROLD I	BERKS
FARHI, MD, FARIDEH T	LUZERNE
FARIES JR, MD, GEORGE B	DAUPHIN
FARKAS, MD, ANDREW A	JEFFERSON
FARKAS, MD, BARRY L	ALLEGHENY
FARKAS, MD, ROBERT W	YORK
FARLEY, TRACI L	STUDENT
FARMATI, MD, OSCAR	CRAWFORD
FARMER, DO, JOHN E	FRANKLIN
FARMER, MD, JOHN L	LANCASTER
FARMER, MD, LENORE	ALLEGHENY
FARNEY, MD, ESTHER S	ALLEGHENY
FARNON, MD, CHRISTA U	PHILADELPHIA
FARONE, DO, FRANK G	LAWRENCE
FAROOQUE, MD, MUSTAFA	MONTGOMERY
FARR, MD, JAMES	LEHIGH
FARR, MD, RUSSELL M	BEAVER
FARRAH, DO, VICTOR B	CRAWFORD
FARRAR JR, MD, GEORGE E	PHILADELPHIA
FARRELL, MD, DINA M	MONTOUR
FARRELL, MD, DOROTHY A	LUZERNE
FARRELL, MD, EDWARD L	ALLEGHENY
FARRELL, MD, LEO D	DAUPHIN
FARRELL, MD, MICHAEL J	ALLEGHENY
FARRELL, MD, PETER E	LEHIGH
FARRELL, MD, ROBERT E	LACKAWANNA
FARRELL, MD, TIMOTHY P	PHILADELPHIA
FARRELL, MD, TIMOTHY P	DAUPHIN
FARRELL, MD, WILLIAM J	LACKAWANNA
FARZIN, MD, FARZANEH	STUDENT
FASANO, MD, M THERESA	YORK
FASANO, MD, MICHAEL J	YORK
FASCIANA, MD, GUY M	LUZERNE
FASS, MD, BARRY D	BUCKS
FASS, MD, BONNIE L	PHILADELPHIA
FAST, MD, WILLIS B	BUCKS
FASULO, MD, GREGG J	LANCASTER
FATIGATI, MD, MARIO J	ALLEGHENY
FATTU, MD, JAMES M	PHILADELPHIA
FATULA, MD, GEORGE M	JEFFERSON
FATUR, MD, LEO M	ALLEGHENY
FAULX, MICHAEL D	STUDENT
FAUST, MD, DONALD S	BERKS
FAUST, MD, HERBERT A	CHESTER
FAVA, MD, GEORGE E	LEBANON
FAVINI, MD, PETER J	MONROE
FAWCETT, MD, JAMES L	ALLEGHENY
FAYE, MD, ROBYN B	PHILADELPHIA
FAYNBERG, MD, MARK G	PHILADELPHIA
FAYNBERG, MD, NORA	MONTGOMERY
FAZI, MD, BURT	BLAIR
FAZIO, MD, GREGORY P	YORK
FAZIOLI, MD, LAWRENCE A	LAWRENCE
FAZZOLARI, DO, LISA R	DAUPHIN
FEAR, MD, JESSE G	COLUMBIA
FEASTER, MD, MARSHALL M	BERKS
FECZKO, MD, WILLIAM A	ALLEGHENY
FEDDER, MD, STEPHEN L	DELAWARE
FEDELE, MD, CHARLES R	BRADFORD
FEDERICI, MD, VALERIO J	PHILADELPHIA
FEDERLE, MD, MICHAEL P	ALLEGHENY
FEDERMAN, MD, JAY L	DELAWARE
FEDEROFF, MD, SUSAN T	BEAVER
FEDOK, MD, FREDERICK G	DAUPHIN
FEDULLO, MD, LISA M	NORTHAMPTON
FEDUSKA, MD, RICHARD G	ALLEGHENY
FEE, MD, EUGENE A	MONTGOMERY
FEE JR, MD, WILLIAM H	VENANGO
FEEHAN, MD, PATRICK R	LANCASTER
FEES JR, MD, ARCH W	BLAIR
FEESE, ERIC J	STUDENT
FEFFER, MD, MICHAEL J	BLAIR
FEHNEL, MD, STEPHEN H	BERKS
FEICK, MD, RALPH H	BERKS
FEIG, MD, STEPHEN A	PHILADELPHIA
FEIGENBERG, STEVEN J	STUDENT
FEIN, DO, HOWARD K	MONTGOMERY
FEIN, MD, JOEL A	PHILADELPHIA
FEINBERG, MD, DAVID H	NORTHAMPTON
FEINBERG, MD, HALBERT J	LANCASTER
FEINBERG, MD, KALMEN A	SCHUYLKILL
FEINBERG, MD, STANFORD S	BERKS
FEINSMITH, MD, NORMAN	PHILADELPHIA
FEINSTEIN, MD, ALEX	LANCASTER
FEINSTEIN, MD, PETER A	LUZERNE
FEIST, MD, JOHN H	ALLEGHENY
FELDER, MD, HERMAN	ALLEGHENY
FELDER, MD, MITCHELL S	MERCER
FELDMAN, MD, ARTHUR M	PHILADELPHIA
FELDMAN, MD, ELLA S	PHILADELPHIA
FELDMAN, MD, ELLEN K	MONTGOMERY
FELDMAN, MD, JULIAN D	PHILADELPHIA
FELDMAN, MD, MICHAEL S	NORTHAMPTON
FELDMAN, MD, NATHAN I	SUSQUEHANNA
FELDMAN, DO, NEIL H	LEHIGH
FELDMAN, MD, ROBERT A	PHILADELPHIA
FELDMAN, ROBERT P	STUDENT
FELDMAN, MD, SHERRIE B	DAUPHIN
FELDMAN, MD, STEWART L	ALLEGHENY
FELDMEIER, MD, CURTIS J	BEAVER
FELGAR, MD, RAYMOND E	PHILADELPHIA
FELICE, MD, CIVIE D	ALLEGHENY
FELINS, MD, KELLY J	LACKAWANNA
FELIX, MD, CAROLYN A	PHILADELPHIA
FELIX, MD, DIONISIO	PHILADELPHIA
FELL, MD, BRADLEY A	WESTMORELAND
FELLERMAN, MD, HERBERT	LUZERNE
FELLIN, MD, CHRIS W	MONTOUR
FELLIN, MD, FREDERICK M	PHILADELPHIA
FELLIN, MD, RUDOLPH S	LUZERNE
FELLOWS, MD, KENNETH E	PHILADELPHIA
FELSHER, MD, JONATHAN C	DELAWARE
FELTWELL JR, MD, PETER M	ALLEGHENY
FENCEL, MD, RICHARD M	DAUPHIN
FENELLO, MD, ANTHONY P	BLAIR
FENLIN JR, MD, JOHN M	PHILADELPHIA
FENN, MD, PATRICIA A	MONTGOMERY
FENNER, MD, HENRY E	LAWRENCE
FENSTEMACHER, MD, PAMELA A	MONTGOMERY
FENSTER, MD, MARK E	CLEARFIELD
FERANCHAK, MD, ANDREW P	ALLEGHENY
FERENCE, ANDREA J	STUDENT
FERGUSON, MD, BERRYLIN J	ALLEGHENY
FERGUSON, MD, DONALD G	ALLEGHENY
FERGUSON, MD, GARY M	ALLEGHENY
FERGUSON, MD, ROBERT H	WESTMORELAND
FERGUSON, MD, ROGER J	ALLEGHENY
FERGUSON, DO, STEVEN W	MERCER
FERGUSON, MD, THOMAS G	ALLEGHENY
FERGUSON JR, MD, ALBERT B	ALLEGHENY
FERGUSON JR, MD, GUERRANT H	PHILADELPHIA
FERGUSON JR, MD, THEODORE J	ALLEGHENY
FERLAN, MD, LAWRENCE	ALLEGHENY
FERNANDEZ, MD, ARMANDO E	YORK
FERNANDEZ, MD, EDUARDO I	LYCOMING
FERNANDEZ, MD, JAVIER	PHILADELPHIA
FERNANDEZ, MD, JOSE R	MIFFLIN/JUNIATA
FERNANDEZ, MD, RODOLFO E	ALLEGHENY
FERNANDO, MD, NEVILLE A	ERIE
FERNAU, MD, JAMES L	ALLEGHENY

FERRAN, CLAUDIA M	STUDENT
FERRARA, MD, JOSEPH D	BUCKS
FERRARA, MD, LEONARD P	LEBANON
FERRARA, MD, VINCENT L	PHILADELPHIA
FERRARO, MD, FRANCIS T	ALLEGHENY
FERRARO, MD, MICHAEL M	LUZERNE
FERRARO, MD, PATRICK J	LACKAWANNA
FERRARO, MD, ROBERT J	ERIE
FERREIRA, MD, LISA E	PHILADELPHIA
FERRENTINO, MD, FRANK L	YORK
FERRERO, MD, BRUCE R	ALLEGHENY
FERRETTI, DO, SILVIA M	ERIE
FERRIE, MD, PATRICIA M	PHILADELPHIA
FERRIER, MD, MELVIN C	CENTRE
FERRIGNO JR, MD, C JAMES	COLUMBIA
FERRIS, MD, JAMES V	ALLEGHENY
FERRY, MD, GERALD W	BERKS
FERRY, MD, NICHOLAS J	BUCKS
FESSLER, MD, THOMAS J	ERIE
FETCHKO, MD, ALEXANDER M	ALLEGHENY
FETTERMAN, MD, HENRY H	LEHIGH
FETTERMAN, HILARY C	STUDENT
FETTEROLF, MD, DONALD E	ALLEGHENY
FETTEROLF, MD, MICHAEL L	VENANGO
FETZER, MD, ARTHUR E	LEHIGH
FEUDALE, MD, RICHARD F	SCHUYLKILL
FEUSSNER, MD, JAMES W	PHILADELPHIA
FIALKOV, JONATHAN	STUDENT
FICKE, MD, J RONALD	PHILADELPHIA
FIDELER, MD, RICHARD	DAUPHIN
FIDLER, SUZANNE A	STUDENT
FIEDLER, ELIZABETH I	STUDENT
FIEDLER, MD, ERIC P	ALLEGHENY
FIEDLER, MD, JAMES J	PHILADELPHIA
FIEDLER, MD, ROY W	ALLEGHENY
FIEHLER, MD, PAUL C	ALLEGHENY
FIELD, MD, HOWARD L	PHILADELPHIA
FIELD MUNVES, MD, ELLEN M	LEHIGH
FIELDS, MD, DAVID R	LUZERNE
FIELDS, MD, RONALD H	BUCKS
FIENGO, DO, MARK N	PHILADELPHIA
FIEO, MD, ANDREW G	DAUPHIN
FIERER, MD, ROBERT R	DAUPHIN
FIERRO, MD, RONALD F	ALLEGHENY
FIERRO, DO, VINCENT S	ERIE
FIFE, WILLIAM C	STUDENT
FIGLIN, DO, JOSHUA M	CENTRE
FIGUCIA, MD, DAVID A	ALLEGHENY
FIGUEROA, MD, WILLIAM G	PHILADELPHIA
FIGURA, MD, JUDITH H	ALLEGHENY
FILE, MD, JAMES C	MERCER
FILE, PAUL I	STUDENT
FILICKO, MD, JOANNE E	PHILADELPHIA
FILIP, MD, JOHN R	MONTGOMERY
FILIPEK, MD, STEELE W	ALLEGHENY
FILIPEK, MD, WALTER J	NORTHAMPTON
FILIPOWICZ, MD, THOMAS A	BUCKS
FILIPPI, MD, RONALD S	ERIE
FILKINS, MD, KAREN	ALLEGHENY
FILLER, MD, JOSEPH J	LUZERNE
FILLMAN, MD, JOHN B	HUNTINGDON
FILMYER JR, MD, EDWARD A	PHILADELPHIA
FILOSA, MD, ROBERT J	MONTGOMERY
FINCH, MD, ALBERTA M	MONROE
FINCH, MD, FRANK G	BERKS
FINDER, MD, MARC J	BEDFORD
FINE, MD, ARTHUR P	ALLEGHENY
FINE, MD, DANIEL	ALLEGHENY
FINE, MD, ERIC W	PHILADELPHIA
FINE, MD, ROBERT	MONTGOMERY
FINE, SHARON R	STUDENT
FINEGOLD, MD, AARON N	ALLEGHENY
FINEGOLD, MD, HELENE	ALLEGHENY
FINEGOLD, MD, JOSEPH	ALLEGHENY
FINEGOLD, MD, RICHARD A	ALLEGHENY
FINEGOLD, MD, WILFRED J	ALLEGHENY
FINESTONE, MD, ALBERT J	PHILADELPHIA
FINESTONE, MD, ISRAEL	PHILADELPHIA
FINESTONE, MD, STEPHEN C	ALLEGHENY
FINGERUT, MD, JERALD C	MONTGOMERY
FINGO, MD, ALBERT J	MONTGOMERY
FINIKIOTIS, MD, MICHAEL W	ALLEGHENY
FINK, MD, GORDON B	PHILADELPHIA
FINK, MD, JACK W	MONTGOMERY
FINK, MD, PAUL J	PHILADELPHIA
FINK JR, MD, ALBERT H	DELAWARE
FINK JR, MD, HOWARD E	DAUPHIN
FINKELSTEIN, MD, DAVID	PHILADELPHIA
FINKELSTEIN, DAVID H	STUDENT
FINKELSTEIN, MD, GARY S	BUCKS
FINKELSTEIN, MD, JEFFREY M	PHILADELPHIA
FINKELSTEIN, DO, LEONARD H	MONTGOMERY
FINKELSTON, MD, MIA B	DAUPHIN
FINKENSTADT, MD, ERIC V	PHILADELPHIA
FINLEY, MD, JOHN G	BUCKS
FINN, MD, DANIEL T	STUDENT
FINN, MD, DAVID R	LYCOMING
FINN, MD, DORON H	WASHINGTON
FINN, MD, JOANNE	ERIE
FINN, MD, JOSEPH L	PHILADELPHIA
FINN, MD, MARTHA J B	LYCOMING
FINNEGAN, MD, WALTER J	LEHIGH
FINO, MD, GREGORY	LUZERNE
FINO, MD, JULIUS A	WARREN
FIOL-SILVA, MD, ZORAIDA M	PHILADELPHIA
FIORAVANTI, MD, FRED K	ALLEGHENY
FIORELLI, DO, ROBERT L	LUZERNE
FIORICA, MD, VINCENT M	CAMBRIA
FIORINI, MD, CYNTHIA M	ALLEGHENY
FIREMAN, MD, ANDREW S	PHILADELPHIA
FIREMAN, MD, PHILIP	ALLEGHENY
FIRME, MD, STEVE RANDAL E	DELAWARE
FIRPO JR, MD, JOHN J	DELAWARE
FIRST, MD, HOWARD E	PHILADELPHIA
FIRST, MD, STEWART E	PHILADELPHIA
FISCHBEIN, MD, RICHARD E	LUZERNE
FISCHER, MD, DAVID H	PHILADELPHIA
FISCHER, MD, EDWARD C	BERKS
FISCHER, MD, EDWARD P	BLAIR
FISCHER, MD, H KEITH	PHILADELPHIA
FISCHER, MICHELLE A	STUDENT
FISCHER, MD, SHARON P	PHILADELPHIA
FISCHER, MD, STEVEN W	DELAWARE
FISCHER JR, MD, CARL R	PHILADELPHIA
FISCHETTI, MD, JOHN L	CHESTER
FISCHL, MD, EDWIN C	ALLEGHENY
FISH, MD, JAMES E	PHILADELPHIA
FISH, MD, LARRY A	ALLEGHENY
FISHER, DO, CLAUDIA C	BERKS
FISHER, MD, CURTIS K	ALLEGHENY
FISHER, MD, DON L	ALLEGHENY
FISHER, MD, GAIL	ALLEGHENY
FISHER, DO, GARY A	PHILADELPHIA
FISHER, MD, HAROLD	YORK
FISHER, MD, JAY B	NORTHAMPTON
FISHER, MD, JOANNA M	PHILADELPHIA
FISHER, MD, JOHN T	CENTRE
FISHER, MD, JOSEPH S	PHILADELPHIA
FISHER, MD, MARY S	PHILADELPHIA
FISHER, MD, NORMAN J	MONTGOMERY
FISHER, ROBERT J	STUDENT
FISHER, MD, ROBERT M	MONTGOMERY
FISHER, MD, ROBERT S	PHILADELPHIA
FISHER, MD, SARAH M	PHILADELPHIA
FISHER, DO, SCOTT A	PHILADELPHIA
FISHER, MD, SCOTT R	ALLEGHENY
FISHER, MD, SETH M	PHILADELPHIA
FISHER, MD, STEPHEN N	ALLEGHENY
FISHER, TODD M	STUDENT
FISHER, MD, TODD R	DAUPHIN
FISHER III, MD, GEORGE R	PHILADELPHIA
FISHER JR, MD, JOSEPH W	NORTHAMPTON
FISHMAN, DO, MORRIS A	PHILADELPHIA
FISHMAN, DO, ROBERT F	PHILADELPHIA
FISSEL, BRETT S	STUDENT
FISSEL, MD, GEORGE E	LYCOMING
FISTER, MD, FREDERICK D	LEHIGH
FITTING JR, MD, GEORGE M	ALLEGHENY
FITTS, MD, LINDA E	NORTHAMPTON
FITZ, MD, RALPH W	ALLEGHENY
FITZGERALD, DO, JOHN J	MONTGOMERY
FITZGERALD, MD, RICHARD P	DAUPHIN
FITZMAURICE, MD, JOHN W	DELAWARE
FITZPATRICK, DO, JAMES W	SCHUYLKILL
FITZPATRICK, MD, LUCRETIA A	DELAWARE
FITZPATRICK, MD, MARCIA A	DELAWARE
FITZPATRICK, MD, MICHAEL J	PHILADELPHIA
FITZPATRICK, MD, RUTHANN P	DELAWARE
FITZSIMMONS, MD, AMY S	DELAWARE
FIUME, MD, THOMAS J	LACKAWANNA
FLACCAVENTO, MD, FREDERICK G	YORK
FLACCO, MD, ALBERT J	BUCKS
FLAGG, MD, ALICE W	PHILADELPHIA
FLAHERTY, MD, MORGAN F	ALLEGHENY
FLAMBERG, MD, IRA W	MERCER
FLAMINI, MD, JOHN A	ERIE
FLAMM, MD, EUGENE S	PHILADELPHIA
FLANAGAN, MD, JOSEPH C	DELAWARE
FLANAGAN, MD, MARGARET M	FRANKLIN
FLANIGAN, MD, ROBERT E	ALLEGHENY
FLANNAGAN, MD, SAMUEL W	WESTMORELAND
FLANNERY, MD, WILBUR E	LAWRENCE
FLASHNER, MD, STEVEN C	BUCKS
FLEAGLE, MD, GENEVRA S	CENTRE
FLEEGLER, MD, FRANCENE M	PHILADELPHIA
FLEEGLER, MD, SAUL M	WESTMORELAND
FLEISCHER, MD, ALAN N	BERKS
FLEISCHER, MD, DEBORAH E	MONTGOMERY
FLEISCHER, MD, LEROY B	DELAWARE
FLEISHER, DO, RICHARD D	PHILADELPHIA
FLEISHMAN, MD, MARTIN J	MIFFLIN/JUNIATA
FLEMENS, NATASHA L	STUDENT
FLEMING, MD, ARTHUR W	ALLEGHENY
FLEMING, MD, BURTON A	PHILADELPHIA
FLEMING, MD, RICHARD X	DAUPHIN
FLEMMING, MD, MATTHEW A	PHILADELPHIA
FLETCHER, MD, THOMAS F	DAUPHIN
FLETMAN, DO, HERBERT	PHILADELPHIA
FLICKINGER, MD, FREDERICK W	ADAMS
FLICKINGER, MD, HAVILAND	MONTGOMERY
FLICKINGER, MD, JOHN C	ALLEGHENY
FLIT, MD, FRANK J	ALLEGHENY
FLITTER, MD, MARC A	ERIE
FLOM, MD, DAVID M	ALLEGHENY
FLOM, MD, LYNDA L	ALLEGHENY
FLOOD, MD, JAMES M	BRADFORD
FLOOD, MD, KATHERINE M	ALLEGHENY
FLOOD, MD, MICHAEL S	LANCASTER
FLORA, MD, WILLIAM K	CAMBRIA
FLOREK, MD, FLORIAN F	ERIE
FLORENCE, MD, DAVID W	DAUPHIN
FLORENTIN, MD, HERIBERTO M	WESTMORELAND
FLORES, ALAN G	STUDENT
FLORES, MD, ALBERTO C	LANCASTER
FLORES, MD, CARLOS I	LAWRENCE
FLORES, MD, EVELYN R	BERKS
FLORES, MD, MARIA L	DELAWARE
FLORES, MD, MAY R	FAYETTE
FLORES JR, MD, EMILIO G	ELK/CAMERON
FLORIAN, MD, FREDERICK M	ALLEGHENY
FLOURAS, MD, KATHY	MONTOUR
FLOWERS, MD, DAVID M	BUCKS
FLOWERS, MD, PETER B	LEBANON
FLOYD, MD, SUSAN L	ALLEGHENY
FLURKEY, MD, EMERSON C	DAUPHIN
FLYNN, MD, J DENNIS	BLAIR
FLYNN-RODDEN, MD, KARIN	PHILADELPHIA
FOBIA, MD, JOHN B	PHILADELPHIA
FOCHT, MD, CHERYL A	STUDENT
FODERARO, MD, ANTHONY E	BUCKS
FODERARO, MD, JOHN C	PHILADELPHIA
FOGEL, MD, MARK A	PHILADELPHIA
FOGEL, MD, STEWART R	ALLEGHENY
FOGLEY, MD, ANEES R	LACKAWANNA
FOKSTUEN, MD, TERJE S	MCKEAN
FOLANDER, MD, HAL L	NORTHAMPTON
FOLB, MD, HENRY A	ALLEGHENY
FOLDES, MD, JULIUS	LUZERNE
FOLDES, MD, PETER J	PHILADELPHIA
FOLDES, MD, STEVEN I	MONTOUR
FOLDES-ROTH, MD, ELISABETH	BERKS
FOLEY, MD, T RAYMOND	LANCASTER
FOLEY JR, MD, EDWARD L	WASHINGTON
FOLK, MD, JEFFREY R	LUZERNE
FOLK, DO, MARK E	LANCASTER
FOLLWEILER, MD, BARRY R	LEHIGH
FOLTZ, EXEC SEC, SUSAN	LEBANON
FONG, MD, JAKE	WESTMORELAND
FONG, MD, JOHN K	ALLEGHENY
FONOROFF, MD, DAVID L	ALLEGHENY
FONTANA, MD, ARMAND L	ALLEGHENY
FONTANA, MD, FRANK L	ALLEGHENY
FOOR, MD, JEFFREY L	BEDFORD
FORAUER, MD, ANDREW R	ALLEGHENY
FORBES, MD, J DEXTER	ALLEGHENY
FORBES, MD, THOMAS W	ALLEGHENY
FORCE, MD, THOMAS B	PHILADELPHIA
FORCEY, MD, LLOYD R	LYCOMING
FORD, MD, D PATRICK	PHILADELPHIA
FORD, MD, FRANCIS W	BUCKS
FORD, MD, ROBERT W	ALLEGHENY
FORD, DO, STACEY G	BERKS
FORD, MD, WILLIAM T	LYCOMING
FOREST, MD, JEAN L	PHILADELPHIA
FORGIONE JR, MICHAEL A	STUDENT
FORKER, MD, THOMAS	LEBANON
FORKER, MD, THOMAS S	LYCOMING
FORKEY, MD, HEATHER C	PHILADELPHIA
FORMAN, MD, BRUCE H	CHESTER
FORMAN, DEENA R	STUDENT
FORMAN, MD, HOWARD I	PHILADELPHIA
FORMAN, MD, IRWIN H	LANCASTER
FORMAN, MD, JOSEPH E	PHILADELPHIA
FORMAN, MD, KENNETH J	PHILADELPHIA
FORMAN, MD, STANLEY O	MONTGOMERY
FORMAN, MD, STEVEN D	ALLEGHENY
FORMANEK, MD, GREGORY A	BLAIR
FORNASIER, MD, LOUIS S	DELAWARE
FORNWALT, MD, GEORGE R	DELAWARE
FORNWALT, MD, HELEN L	PHILADELPHIA
FORRY, EXEC SEC, CANDY K	MONROE
FORSTATER, MD, ALAN T	PHILADELPHIA
FORSTEIN, DO, DAVID A	PHILADELPHIA
FORSTER, DO, CARL J	SCHUYLKILL
FORSTER, MD, TERRENCE J	BUCKS
FORSYTHE, MD, DANNY W	STUDENT
FORSYTHE, MD, PATRICK D B	DAUPHIN
FORTI, MD, WILLIAM P	DAUPHIN
FORTIER, MD, GREGORY A	YORK
FORTINO, MD, GREGG L	PHILADELPHIA
FORTNA, MD, SANDRA J	ERIE
FORTUNATO, MD, JAMES J	ALLEGHENY
FORTUNER, MD, WILLIAM J	LEBANON
FOSTER, MD, EDWIN N	YORK
FOSTER, MD, HOWARD K	ALLEGHENY
FOSTER, MD, IAN S	MONROE
FOSTER, MD, JOHN S	CHESTER
FOSTER, MD, RICHARD G	ALLEGHENY
FOSTER, MD, SYLVIA L	MONTGOMERY
FOSTER, DO, TROY D	WASHINGTON
FOSTER, MD, WALTER D	WESTMORELAND
FOSTER JR, MD, FREDERICK G	BUTLER
FOSTER-DRAIN, MD, ROBIN L	PHILADELPHIA
FOULSHAM II, MD, CHARLES K	CLINTON
FOURNIER, MD, RAYMOND	LACKAWANNA
FOUST, MD, TILMAN H	DAUPHIN
FOUST, MD, WILSON A	LANCASTER
FOWBLE, MD, BARBARA	PHILADELPHIA
FOWLER, MD, DAVID P	ALLEGHENY
FOWLER, MD, ERIC K	MIFFLIN/JUNIATA
FOX, COLEEN L	STUDENT
FOX, MD, CRAIG D	WASHINGTON
FOX, MD, DONALD C	BUTLER
FOX, MD, KENNETH L	PHILADELPHIA
FOX, MELISSA B	STUDENT
FOX, MD, MICHAEL L	MONTGOMERY
FOX, MD, ROBERT D	PHILADELPHIA
FOX, MD, ROGER E	DELAWARE
FOX, MD, SARAH D	ALLEGHENY
FOX, MD, WILLIAM W	PHILADELPHIA
FOX IV, MD, JAMES W	PHILADELPHIA
FOXX, MD, WILLIAM F	CHESTER
FRABLE, MD, DEAN G	SCHUYLKILL
FRAC, MD, MICHAEL J	ALLEGHENY
FRAGOLA, MD, JORGE A	ALLEGHENY
FRAIFELD, MD, MOISES	PHILADELPHIA
FRALEY, MD, EDITH L	ALLEGHENY
FRALEY, MD, HENRY W	ARMSTRONG
FRAME, MD, DAVID C	WASHINGTON
FRAME, MD, WILLIAM A	NORTHAMPTON
FRANCE, MD, LAURENCE W	LANCASTER
FRANCE, MD, ROBERT O	LYCOMING
FRANCESCANGELI JR, MD, VINCENT	MONROE
FRANCHINO, MD, CHARLES J	PHILADELPHIA
FRANCIS, MD, GEORGE J	ALLEGHENY
FRANCIS, MD, LEON R	LUZERNE
FRANCIS, DO, MARLOWE S	CHESTER
FRANCKEN, MD, GREGORY J	WESTMORELAND
FRANCO, MD, FRANK A	BERKS
FRANCO, MD, THOMAS J	ALLEGHENY
FRANCOIS, MD, MAX B	BERKS
FRANCOS, MD, CHARLES G	LANCASTER
FRANGOS, MD, JAMES N	LACKAWANNA
FRANK, MD, BARBARA B	DELAWARE
FRANK, MD, EVAN D	PHILADELPHIA
FRANK, MD, HERBERT L	DAUPHIN
FRANK, MD, JEFFREY B	BERKS
FRANK, MD, LEONARD A	MONTGOMERY
FRANK, MD, LESLIE A	ALLEGHENY
FRANK, MD, MARTIN N	MONTGOMERY
FRANK, MD, PAUL E	MONTGOMERY
FRANK, MD, ROBERT L	MONTGOMERY
FRANK, DO, RONALD B	MONTGOMERY
FRANK, MD, TOBY L	MONTGOMERY
FRANK, MD, WILLIAM O	PHILADELPHIA
FRANKEL, MD, ANDREW S	CHESTER
FRANKEL, MD, ARTHUR M	MONTGOMERY
FRANKEL, MD, CARL A	DAUPHIN
FRANKEL, MD, HARRY A	PHILADELPHIA
FRANKEL, MD, LEON A	PHILADELPHIA
FRANKEL, MD, LESLIE B	MONTGOMERY
FRANKEL, MD, MATTHEW C	PHILADELPHIA
FRANKEL, MD, SHARON R	DAUPHIN
FRANKEL, MD, VICTOR R	PHILADELPHIA
FRANKENFIELD, MD, BRUCE A	LEHIGH
FRANKENSTEIN, MD, HERBERT	ALLEGHENY
FRANKENY II, MD, JOHN R	DAUPHIN
FRANKL, MD, WILLIAM S	PHILADELPHIA
FRANKLIN, MD, IRVIN D	BUCKS
FRANKLIN, MD, JOHN W B	ALLEGHENY
FRANKLIN, MD, NORMAN	ERIE
FRANKOVITCH, MD, KARL F	ERIE
FRANKS, MD, JAMES F	LUZERNE
FRANTZ, MD, ALFRED S	FRANKLIN
FRANTZ, MD, LINDA S	LACKAWANNA
FRANZ, BETTINA E	STUDENT
FRANZ, MD, JOHN P	ALLEGHENY
FRANZ, DO, MARK G	FAYETTE
FRANZ, MD, PAMELA J	PHILADELPHIA
FRANZ, MD, THOMAS A	ALLEGHENY
FRANZEL, MD, SUSAN L	PHILADELPHIA
FRANZONI, MD, GARRETT M	MONTOUR
FRATTALI, MD, AUGUST	LACKAWANNA
FRATTALI, MD, MARY J	LACKAWANNA
FRAUNFELDER, MD, JOHN A	NORTHAMPTON
FRAYER, MD, WILLIAM C	PHILADELPHIA
FRAZIER, MD, THOMAS G	MONTGOMERY
FRAZIER II, MD, JOHN E	ALLEGHENY
FREDANE, MD, LEWIS M	PHILADELPHIA
FREDERIC, MD, MYRON W	PHILADELPHIA
FREDERICK, MD, PAUL L	ARMSTRONG
FREDERICKS, MD, LILLIAN E	PHILADELPHIA
FREDERICKSON, MD, HOWARD N	YORK
FREDRICKSON, MD, VICTOR J	BUCKS
FREEBERG, MD, JOHN R	MONTGOMERY
FREED, MD, CLARENCE L	BUCKS
FREED, MD, MARTIN I	PHILADELPHIA
FREEDBERG, MD, LAWRENCE E	WESTMORELAND
FREEDMAN, MD, ABRAHAM G	PHILADELPHIA
FREEDMAN, MD, ALLAN P	PHILADELPHIA
FREEDMAN, MD, DONALD B	DAUPHIN
FREEDMAN, MD, E FANNIE	PHILADELPHIA
FREEDMAN, MD, JACOB J	PHILADELPHIA
FREEDMAN, MD, LAWRENCE T	MONTGOMERY
FREEDMAN, MD, LOUIS J	LUZERNE
FREEDMAN, DO, MITCHELL K	PHILADELPHIA
FREEDMAN, DO, SUSAN R	CENTRE
FREELAND, MD, CYNTHIA A	MONTOUR
FREELAND, MD, GEORGE R	DELAWARE
FREEMAN, MD, ALBERT W	FRANKLIN
FREEMAN, MD, DANIAL M A	MONTGOMERY
FREEMAN, MD, RICHARD E	POTTER
FREEMAN, MD, WILLIAM A	FRANKLIN
FREENOCK JR, MD, THOMAS F	DELAWARE
FREER, MD, CAROL V	YORK
FREESE, MD, ANDREW	DELAWARE
FREID, MD, JEFFREY D	BUCKS
FREIFELD, MD, MARTIN L	LUZERNE
FREIMAN, MD, DAVID B	PHILADELPHIA
FREIMUTH, MD, ERICH J	MONTGOMERY
FREIRE, MD, JORGE E	PHILADELPHIA
FREITAG, MD, WARREN B	ALLEGHENY
FREIWALD, MD, MILTON J	PHILADELPHIA
FREMER, MD, ABRAHAM	PHILADELPHIA
FRENCH, MD, ELIZABETH G	CHESTER
FRENCH, MD, GORDON N	CHESTER
FRENCH, MD, TRAVIS A	LAWRENCE
FRENCH, MD, WILLIAM M	UNION
FRESHMAN, MD, JOHN R	DAUPHIN
FREUDENBERG, MD, DORIS T	MONTGOMERY
FREY, MD, JACQUELINE M	YORK
FREY, MD, JEFFREY A	YORK
FRIBERG, MD, THOMAS R	ALLEGHENY
FRICCHIONE, MD, PATRICK J	LACKAWANNA
FRICK JR, MD, EDWARD J	STUDENT
FRICKER, MD, EDWARD J	BRADFORD
FRIDAY, MD, DANIEL M	BLAIR
FRIDAY, MD, JOHN R	ALLEGHENY
FRIDAY, MD, RUPERT H	ALLEGHENY

FRIDAY JR, MD, GILBERT A	ALLEGHENY
FRIEBERT, MD, SARAH	PHILADELPHIA
FRIED, DO, GORDON W	MONROE
FRIED, MD, GUY W	PHILADELPHIA
FRIED, MD, JEFFREY A	INDIANA
FRIED, MD, LINDA F	ALLEGHENY
FRIED, MD, ROBERT C	CHESTER
FRIED, MD, ROBERT T	YORK
FRIEDBERG, MD, ANDREA L	MONTGOMERY
FRIEDBERG, MD, JAY G	BUCKS
FRIEDBERG, MD, MILTON J	LEHIGH
FRIEDEL, JEFFREY M	STUDENT
FRIEDENBERG, MD, STEVEN S	NORTHAMPTON
FRIEDENBERG, MD, ZACHARY B	PHILADELPHIA
FRIEDLANDER, MD, MARK S	DELAWARE
FRIEDLANDER, MD, MILTON A	DAUPHIN
FRIEDMAN, MD, ABRAHAM W	ALLEGHENY
FRIEDMAN, MD, ADELE K	PHILADELPHIA
FRIEDMAN, MD, ALAN LEE	PHILADELPHIA
FRIEDMAN, MD, AMY L	PHILADELPHIA
FRIEDMAN, MD, BART J	WESTMORELAND
FRIEDMAN, MD, CARL J	CHESTER
FRIEDMAN, MD, CLAIRE L	PHILADELPHIA
FRIEDMAN, DO, DAVID S	MONTGOMERY
FRIEDMAN, MD, DONALD	DELAWARE
FRIEDMAN, MD, ELLIS F	BERKS
FRIEDMAN, MD, HENRY B	LUZERNE
FRIEDMAN, MD, JERALD N	NORTHAMPTON
FRIEDMAN, MD, MARK C	DAUPHIN
FRIEDMAN, MD, PAUL S	PHILADELPHIA
FRIEDMAN, MD, PHILLIP	BUCKS
FRIEDMAN, MD, RICHARD A	PHILADELPHIA
FRIEDMAN, MD, RONALD H	PHILADELPHIA
FRIEDMAN, MD, SIDNEY	PHILADELPHIA
FRIEDMAN, MD, SONIA	PHILADELPHIA
FRIEDMAN, MD, SUMNER H	DAUPHIN
FRIEDMAN, MD, SUSAN A	PHILADELPHIA
FRIEDMANN, DO, DANIEL V	CHESTER
FRIEDRICH, MD, ROLAND	YORK
FRIEDRICH, MD, TOMAS	YORK
FRIEDSAM, MD, PATRICIA L	WASHINGTON
FRIEL, MD, MARGARET A	PHILADELPHIA
FRIEMAN, MD, BARBARA G	PHILADELPHIA
FRIEND, MD, ARTHUR	LUZERNE
FRIES, MD, GENE T	LYCOMING
FRISCH, MD, MARK B	PHILADELPHIA
FRITCHEY JR, MD, JOHN A	DAUPHIN
FRITCHLEY, MD, RODNEY B	CUMBERLAND
FRITER, MD, BARRY S	PHILADELPHIA
FRITZ, MD, WILLIAM D	VENANGO
FRITZ, MD, WILLIAM T	CAMBRIA
FRITZ JR, MD, KARL J	WARREN
FROBESE, MD, ALFRED S	PHILADELPHIA
FROESCHLE, MD, JAMES E	MONROE
FROIX, ANTHONY J	STUDENT
FROMAN, MD, STEPHEN M	BEAVER
FROMME, MD, KENNETH L	DAUPHIN
FRONCZEK JR, MD, WILLIAM M	WASHINGTON
FRONDUTI, MD, LUCIAN J	WESTMORELAND
FRONDUTI, MD, ROBERT L	ALLEGHENY
FROOZAN, MD, HOMAYOON	LACKAWANNA
FROST, MD, ALBERT G	MONTGOMERY
FROST, MD, STEPHEN S	PHILADELPHIA
FROST JR, MD, WILLIAM W	WASHINGTON
FRUMIN, MD, ABRAHAM M	PHILADELPHIA
FRUNCILLO, MD, RICHARD J	PHILADELPHIA
FRY, MD, CHLOE O	DAUPHIN
FRY, MD, ROBERT D	PHILADELPHIA
FRY, MD, ROBERT L	FRANKLIN
FRYCZYNSKI, MD, THADDEUS P	ERIE
FRYE, MD, GLADYS M	LANCASTER
FRYE, DO, JOYCE	PHILADELPHIA
FRYE, MD, PAUL E	ALLEGHENY
FRYE, MD, VERYL F	CLINTON
FRYER, MD, THERESA F	ERIE
FRYLING, BRENT A	STUDENT
FU, MD, FREDDIE H	ALLEGHENY
FUCHS, MD, HANS J	ALLEGHENY
FUCHS, LANCE C	STUDENT
FUDELL, DO, STEPHEN A	PHILADELPHIA
FUERST, MD, NICHOLAS E	WASHINGTON
FUGARO, DO, ANTHONY J	MONTGOMERY
FUGATE, MD, JAMES K	JEFFERSON
FUGATE, DO, JEFFREY S	DAUPHIN
FUGATE JR, MD, HOWARD	JEFFERSON
FUGE, MD, L H	ALLEGHENY
FUHRER, MD, RUSSELL S	ALLEGHENY
FUHRMAN, MD, CARL R	ALLEGHENY
FUISZ, MD, ROBERT E	NORTHAMPTON
FUJIMAGARI, MD, TAK	LAWRENCE
FUKUI, MD, MELANIE B	ALLEGHENY
FUKUI, MD, PAUL T	CHESTER
FULCHIERO, MD, GREGORY J	BLAIR
FULCINITI, MD, ROCCO A	ALLEGHENY
FULD, MD, ROBERT A	LEBANON
FULLER, SUZANNE J	STUDENT
FULLER JR, MD, LONNIE E	PHILADELPHIA
FULTON, MD, WILLIAM O	YORK
FULTZ, MD, CRAIG W	DAUPHIN
FULTZ, SHAWN L	STUDENT
FUMO JR, MD, PETER F	PHILADELPHIA
FUNCH, MD, ROSS S	PHILADELPHIA
FUNG, MD, JOHN J	ALLEGHENY
FUNK JR, MD, ELMER H	PHILADELPHIA
FUNK JR, MD, F COLEMAN	LYCOMING
FUNKE, MD, ALVIN H	COLUMBIA
FUNKHOUSER, MD, JAY L	BEAVER
FUNT, MD, LOREN	ALLEGHENY
FUOCO, MD, JOHN J	MIFFLIN/JUNIATA
FUREY, MD, SANDY A	LACKAWANNA
FUREY JR, MD, CHARLES A	PHILADELPHIA
FURGIUELE, MD, FRANCIS P	MONTGOMERY
FURGIUELE-IRACKI, MD, NATALIE	ALLEGHENY
FURIA, MD, FREDERICK A	DELAWARE
FURIGAY, MD, R L	CAMBRIA
FURMAN, MD, DONALD J	WARREN
FURMAN, MD, FRANK H	CHESTER
FURMAN, MD, JAIME V	PHILADELPHIA
FURMAN, MD, JOSEPH M R	ALLEGHENY
FURMAN, MD, MICHAEL B	PHILADELPHIA
FURNARY, MD, JAMES S	CAMBRIA
FURNER, DO, CARL L	LUZERNE
FURR, MD, CHARLES M	ERIE
FURTADO, MD, FRANCISCO DE A	NORTHMBRLAND
FUSCO, MD, FRANK	MONROE
FUSCO, MD, ROBERT D	ALLEGHENY
FUSCO-RIPKA, MD, GIOVANNA D	BERKS
FUSIA, MD, JOSEPH F	ALLEGHENY
FUSIA JR, MD, DONALD A	WESTMORELAND
FUST, MD, JOHN A	ERIE
FUTCHER, MD, PALMER H	PHILADELPHIA
FUTRELL, MD, J WILLIAM	ALLEGHENY

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GAARY, MD, ALVIN E	DELAWARE
GABALA, MD, JOHN M	NORTHMBRLAND
GABALE, MD, DEVDATTA R	PHILADELPHIA
GABOS, MD, CHARLES W	ALLEGHENY
GABOS, MD, DENNIS K	ALLEGHENY
GABOS, MD, PAUL	ALLEGHENY
GABRIEL, MD, DANIEL E	WASHINGTON
GABRIEL, MD, JOSUE P	PHILADELPHIA
GABRIEL, MD, LARRY C	LAWRENCE
GABRIEL, MD, LOUIS T	SCHUYLKILL
GABRIEL, MD, PETER	FAYETTE
GABRIEL, MD, STEVEN A	LAWRENCE
GABRIEL, MD, VERONICA	MONTGOMERY
GABRIELE, MD, AUGUST A	YORK
GABROY, MD, ALLEN S	DELAWARE
GABUZDA, MD, THOMAS G	PHILADELPHIA
GADANI, MD, MANU R	CUMBERLAND
GADBOIS, MD, WILLIAM F	NORTHAMPTON
GAERLAN, MD, MARIA S	PHILADELPHIA
GAFFIELD, MD, JAMES	STUDENT
GAFFNEY, DANA E	STUDENT
GAFFNEY, MD, MICHAEL B	ALLEGHENY
GAFFNEY, MD, PAUL C	ALLEGHENY
GAFFORD, MD, GRADY D	TIOGA
GAGIANAS, MD, PETER J	ALLEGHENY
GAGLIARDI, MD, MICHAEL D	ALLEGHENY
GAIA, MD, JUAN D	LUZERNE
GAIN, MD, THOMAS B	PHILADELPHIA
GAINOR, MD, PATRICIA A	FAYETTE
GAISER, MD, ROBERT R	PHILADELPHIA
GAISFORD, MD, JOHN C	ALLEGHENY
GAITHER, MD, HERBERT	DAUPHIN
GAJDOWSKI, MD, RICHARD J	ERIE
GAJULA, MD, L NARAYAN	CARBON
GALANTE, MD, LISA	PHILADELPHIA
GALASSI JR, MD, JOSEPH W	MONTGOMERY
GALASSO, MD, GWENDOLYN M	LUZERNE
GALASSO III, DO, JAMES W	LUZERNE
GALATI, MD, VICTOR G	DELAWARE
GALBREATH, MD, JOHN W	DAUPHIN
GALDUN, MD, JOHN P	ALLEGHENY
GALELLA, MD, NANCY M	MONTGOMERY
GALENA IV, MD, EDWARD C	PHILADELPHIA
GALGON, MD, JOHN P	LEHIGH
GALIB, MD, SAMUEL H	CHESTER
GALIETTA, MD, MARYANN C	BUCKS
GALINS, LINDA S	STUDENT
GALINSKY, MD, DAVID E	MONTGOMERY
GALLAGER, MD, JAMES G	MONTOUR
GALLAGHER, MD, BRYAN J	DAUPHIN
GALLAGHER, MD, CHRISTOPHER J	PHILADELPHIA
GALLAGHER, MD, DORIS B	MONTGOMERY
GALLAGHER, ERIC L	STUDENT
GALLAGHER, MD, HENRY G	LUZERNE
GALLAGHER, MD, JOHN E	ARMSTRONG
GALLAGHER, DO, JOHN M	ERIE
GALLAGHER, MD, JOHN T	BUCKS
GALLAGHER, KIMBERLY M	STUDENT
GALLAGHER, MD, MICHAEL D	YORK
GALLAGHER, MD, MICHAEL J	LACKAWANNA
GALLAGHER, MD, PHILIP E	ERIE
GALLAGHER, DO, THOMAS C	BUCKS
GALLAGHER-SHRIFT, MD, KATHERINE A	DAUPHIN
GALLEN, MD, JOHN H	BERKS
GALLETTA, MD, ANTHONY S	WASHINGTON
GALLI, DO, WILLIAM P	STUDENT
GALLIA, MD, FRANCIS J	DAUPHIN
GALLIS, MD, CHRISTINE M	ALLEGHENY
GALLIVAN, MD, MARY E	PHILADELPHIA
GALLO, MD, RICHARD A	ALLEGHENY
GALLOWAY, MD, GLORIA M	ALLEGHENY
GALLOWAY, MD, JOHN A	CLINTON
GALOS, MD, RICHARD S	ALLEGHENY
GALPERIN, MD, ZHANNA V	PHILADELPHIA
GALTMAN, MD, LAWRENCE M	LEHIGH
GALUS, MD, MARIA A	PHILADELPHIA
GAMBETTA, MD, ESMERALDA	PHILADELPHIA
GANDHI, MD, ANANT J	ALLEGHENY
GANDHI, MD, HARSH	LUZERNE
GANDY, DO, DANIEL R	LYCOMING
GANGESTAD, ANGELINA K	STUDENT
GANIBAN, MD, JUSTINIANO S	PHILADELPHIA
GANIME, MD, PETER D	MONTGOMERY
GANNON, MD, MARK P	ALLEGHENY
GANNON, MD, REYNALDO T	CAMBRIA
GANNON, MD, ROBERT P	ALLEGHENY
GANSNER, MD, ROBYN K	BERKS
GANTER, DO, GERARD C	PHILADELPHIA
GANTI, MD, MURTY S	ALLEGHENY
GARBAK, MD, FRANK	PHILADELPHIA
GARBARINO, MD, JOSEPH L	NORTHAMPTON
GARBELY, DO, JOSEPH M	MONTGOMERY
GARBER, MD, EDWARD H	YORK
GARBER, MD, H JORDAN	ALLEGHENY
GARBERINA, MATTHEW J	STUDENT
GARCIA, MD, ALFREDO J	BUTLER
GARCIA, MD, ANTONIO S	BERKS
GARCIA, MD, CELSO R	PHILADELPHIA
GARCIA, MD, DIOSDADO A	ALLEGHENY
GARCIA, MD, DOMINADOR I	CHESTER
GARCIA, MD, DOMINGO A	FRANKLIN
GARCIA, MD, GERALD D	ERIE
GARCIA, MD, GERARDO M	NORTHAMPTON
GARCIA, MD, GUILLERMO	DAUPHIN
GARCIA, MD, JOSE A	DAUPHIN
GARCIA, MD, JOSE R	LEHIGH
GARCIA, MD, LAUREANO P	PHILADELPHIA
GARCIA, MARIA M	STUDENT
GARCIA, MD, MARIAN	CENTRE
GARCIA, MD, MARK J	ALLEGHENY
GARCIA, MD, MICHAEL J	NORTHAMPTON
GARCIA MANERO, MD, GUILLERMO	PHILADELPHIA
GARDEN, MD, JACK L	PHILADELPHIA
GARDEN, MD, MARC DAVID	PHILADELPHIA
GARDENER, MD, RALPH	ALLEGHENY
GARDINER JR, MD, GEOFFREY A	PHILADELPHIA
GARDNER, MD, ALAN M	CHESTER
GARDNER, DO, BONNIE J	PHILADELPHIA
GARDNER, MD, GEORGE E	YORK
GARDNER, DO, MARSHALL K	PHILADELPHIA
GARDNER, MD, MORRIS Z	ALLEGHENY
GARDNER, MD, ROBERT S	ALLEGHENY
GARDNER, ROBERT W	STUDENT
GARDNER, MD, STUART A	LAWRENCE
GARDNER JR, MD, JAMES L	LAWRENCE
GARDYASZ, MD, MIROSLAW D	DAUPHIN
GAREIS, MD, JOHN W	LANCASTER
GAREY, MD, HERMAN S	LACKAWANNA
GARFINKEL, MD, MARC E	ALLEGHENY
GARFINKEL, MICHAEL D	STUDENT
GARFINKLE, MD, WILLIAM B	PHILADELPHIA
GARG, MD, AJAY P	PHILADELPHIA
GARG, ANJU	STUDENT
GARG, RUCHIRA	STUDENT
GARIBIAN, MD, GARO S	PHILADELPHIA
GARINO, MD, LUCIA A	PHILADELPHIA
GARMAN, MD, RAY F	BRADFORD
GARMAN, MD, STEVE M	YORK
GARNER, MD, BLAINE R	BUCKS
GARNER, MD, WILLIAM J	ALLEGHENY
GARNET, MD, JAMES D	PHILADELPHIA
GAROFALO, MD, CARL A	FAYETTE
GAROFOLA, MD, JOHN H	LANCASTER
GAROFOLI, MD, CAESAR A	ALLEGHENY
GARREN, MD, WENDELL B	ALLEGHENY
GARRETT, MD, JEFFREY S	ALLEGHENY
GARRETT, MD, KEVIN O	ALLEGHENY
GARRETT JR, MD, WILLIAM S	ALLEGHENY
GARRIDO, MD, EDDY	LANCASTER
GARRIOTT, MD, JOHN C	MERCER
GARROTT, MD, JOHN W	ARMSTRONG
GARSON, MD, WARFIELD	ALLEGHENY
GARTLAND, DO, CHARLES J A	DELAWARE
GARTLAND, MD, JOHN J	PHILADELPHIA
GARTNER, MD, WILLIAM S	DELAWARE
GARTNER JR, MD, WILLIAM S	DELAWARE
GARVER, MD, JAMES J	ALLEGHENY
GARVER, MD, KENNETH L	ALLEGHENY
GARVEY, MD, EDMUND P	LANCASTER
GARVEY, MD, WILLIAM P	ERIE
GARZA, MD, JAIME R	ALLEGHENY
GARZARELLI, MD, DAVID M	ALLEGHENY
GASCON, MD, PERLA G	PHILADELPHIA
GASH, MD, ARNOLD K	PHILADELPHIA
GASH, MD, RICHARD M	PHILADELPHIA
GASIC, MD, ANDREI C	CHESTER
GASKINS, MD, ALBERT L	PHILADELPHIA
GASOWSKI, MD, GARY L	YORK
GASPAR, MD, VICENTA C	PHILADELPHIA
GASPAR, MD, VICTORIA S	PHILADELPHIA
GASPARI, MD, RAYMOND J	YORK
GASTALDO, MD, JOHN A	LANCASTER
GASTINEAU, MD, ROBERT M	ALLEGHENY
GASTON, DO, JERRY G	PHILADELPHIA
GASTON, MD, NOREEM M	BUCKS
GASULL JR, MD, H ROBERT	PERRY
GATSKI, MD, ROBERT L	MONTOUR
GATTI, MD, DOMINIC L	MONTGOMERY
GATTI, MD, JOSEPH W	INDIANA
GATTUSO JR, MD, JOSEPH W	BLAIR
GAUDIO, MD, JOHN C	LUZERNE
GAUDIO JR, MD, RALPH	ALLEGHENY
GAUGLER, DO, MICHAEL F	HUNTINGDON
GAUL, MD, JAMES J	BUCKS
GAULIN, MD, J CLAUDE	NORTHAMPTON
GAULT, MD, JAMES H	LANCASTER
GAULT, MD, JANICE A	PHILADELPHIA
GAUNTNER, MD, WALLACE C	ALLEGHENY
GAUSE, MD, PAUL E	LANCASTER
GAUSE, MD, TRENTON M	BEAVER
GAUSLING, MD, SHARON C	LEHIGH
GAUSS, MD, WILLIAM F	ALLEGHENY
GAVARONE, DO, DONNA M	PHILADELPHIA
GAVIN, MD, GEORGE M	WESTMORELAND
GAVIN, MD, LAURENCE J	PHILADELPHIA
GAVIN JR, MD, J ROBERT	LACKAWANNA
GAWCHIK, DO, SANDRA M	DELAWARE
GAWLAS, DO, MICHAEL R	DAUPHIN
GAY, MD, THOMAS C	ALLEGHENY
GAYDOS, MD, JOHN D	BEAVER
GAYDOS, MD, THOMAS L	NORTHAMPTON
GAYLOR, MD, DONALD H	LEHIGH
GAYLOR, MD, THEODORE H	LEHIGH
GAYNER, MD, ROBERT S	NORTHAMPTON
GAYNOR, MD, WILLIAM B	LANCASTER
GAZDER, MD, AFTAB A	NORTHMBRLAND
GAZDICK, MD, MARY ANNE	MONTGOMERY
GAZEK, MD, FRANCISCO A	LUZERNE
GAZOWSKI, MD, THOMAS E	LUZERNE
GAZZE, RONALD M	STUDENT
GEADAH, MD, FOUAD A	DAUPHIN
GEARHART, MD, LYSTER M	LEHIGH
GEDDE, MD, STEVEN J	PHILADELPHIA
GEDDES, MD, GISELLE J	CHESTER
GEDENK, MD, MONIQUE	LANCASTER
GEE, MD, WILLIAM	LEHIGH
GEER, MD, FRANK D	LAWRENCE
GEGWICH, MD, FRANK	COLUMBIA
GEGWICH, MD, JOSEPH F	COLUMBIA
GEHL, MD, LEONARD G	ALLEGHENY
GEHL, MD, RICHARD S	ALLEGHENY
GEHMAN, MD, M JACK	BERKS
GEHMAN, MICHAEL J	STUDENT
GEHRING, MD, DAVID A	VENANGO
GEHRIS, MD, JAMES C	NORTHMBRLAND
GEHRIS, MD, LEROY A	BERKS
GEHRON JR, MD, WILLIAM H	LYCOMING
GEIGER, MD, LEONARD R	MONTGOMERY
GEIGLE, MD, CARL F	ERIE
GEISE, DO, STEVEN W	CLINTON
GEIST, MD, AUDREY A	PHILADELPHIA
GELACEK, MD, PHILIP A	ARMSTRONG
GELBLUM, MD, DAPHNA Y	STUDENT
GELEHRTER, MD, JOSEPH	PHILADELPHIA
GELETKA, MD, SUSAN M	ALLEGHENY
GELFAND, MD, JONATHAN L	PHILADELPHIA
GELFAND, MD, STEVEN B	VENANGO
GELFMAN, MD, RUSSELL	MONTOUR
GELLER, MD, JOSEPH	PHILADELPHIA
GELLER, MD, MARK J	ALLEGHENY
GELMAN, MD, BRUCE P	PHILADELPHIA
GELMAN, MD, KENNETH J	STUDENT
GELMAN, MD, RICARDO	PHILADELPHIA
GELOVICH, STEPHEN P	STUDENT
GEMIL, MD, CORAZON G	CHESTER
GEMIL-CORRAL, MD, ANGELITA G	CHESTER
GEMMILL, MD, REGINALD B	YORK
GENDELL, MD, HOWARD M	ALLEGHENY
GENERALOVICH, MD, THOMAS	ALLEGHENY
GENERETTE, MD, PASHA M	YORK
GENERETTE, MD, WILLIAM O	ALLEGHENY
GENNARELLI, MD, THOMAS A	PHILADELPHIA
GENNAULA, MD, CHARLES P	ALLEGHENY
GENOVESE, MD, FRANK N	ARMSTRONG
GENTER, MD, BRUCE E	PHILADELPHIA
GENTILCORE, MD, THOMAS B	ALLEGHENY
GENTILE, MD, ANTHONY F	ALLEGHENY
GENTILE, MD, ANTHONY J	LACKAWANNA
GENTILE, MD, VICTOR G	PHILADELPHIA
GENTILEZZA, MD, KENNETH W	LACKAWANNA
GENTZLER II, MD, RICHARD D	LANCASTER
GEORGE, MD, GARY R	WASHINGTON
GEORGE, MD, JACOB	ERIE
GEORGE, MD, JOHN J	ALLEGHENY
GEORGE, MD, JOHN M	ALLEGHENY
GEORGE, MD, ROBERT A	ALLEGHENY
GEORGE, MD, ROBERT N	ALLEGHENY
GEORGEVICH, MD, PHILIP G	ALLEGHENY
GEORGY, MD, FAROUK M	LYCOMING
GEOSITS, DO, EDWARD E	LEHIGH
GERACI, MD, GASPERE C	DAUPHIN
GERARD, MD, JOSEPH A	ALLEGHENY
GERARD-CIMINERA, MD, JUDY L	MONTGOMERY
GERBER, MD, HARRIS S	PHILADELPHIA
GERBER, DO, MELVIN D	LANCASTER
GERBER, MD, MICHAEL L	ALLEGHENY
GERBER, MD, PAUL	PHILADELPHIA
GERBER, MD, WALTER L	PHILADELPHIA
GERBERT, MD, KATHLEEN H	LANCASTER
GERCHMAN, MD, LEROY B	LEHIGH
GERDES, MD, JEFFREY S	PHILADELPHIA
GERGER, MD, JOSEPH P	WESTMORELAND
GERHARD, MD, WILHELM	DELAWARE
GERHARDT, MICHAEL B	STUDENT
GERHART, MD, GEORGE R	BERKS
GERHART, MD, GUY H	JEFFERSON
GERHART, MD, WILLIS C	MONTGOMERY
GERIG, MD, JOHN S	MONTOUR
GERLACH, MD, DETLEF H	YORK
GERLACH IV, MD, CHARLES D	DAUPHIN
GERMAN, MD, ANTONIO I	ERIE
GERMAN, MD, TERRY M	MONTGOMERY
GERNETH, MD, GEORGE J	ALLEGHENY
GERONIMO, MD, LAURO S	NORTHAMPTON
GERSH, MD, RICHARD N	PHILADELPHIA
GERSHENSON, MD, STEPHEN R	MONTGOMERY
GERSHKOFF, MD, ARTHUR M	PHILADELPHIA
GERSON, MD, ANDREW G	MONTGOMERY
GERSON, MD, BENJAMIN	CHESTER
GERSON, MD, IRVIN M	CHESTER
GERSTADT, MD, KIMBERLY A	PHILADELPHIA
GERSTLEY III, MD, LOUIS	PHILADELPHIA
GERTNER, MD, ERIC J	PHILADELPHIA

GESKEY, JOSEPH M	STUDENT
GESSNER, MD, THOMAS P	WESTMORELAND
GETTE, MD, MICHAEL T	NORTHAMPTON
GETZ, MD, WILLIAM B	PHILADELPHIA
GEVIRTZ, MD, JEFFREY L	LEHIGH
GEVJAN, MD, ARMEN H	DELAWARE
GEYER, MD, DAVID W	BERKS
GHAEMMAGHAMI, MD, CHRIS A	ALLEGHENY
GHASSEMI, MD, REX	PHILADELPHIA
GHATAK, MD, PETER K	NORTHAMPTON
GHATE, MD, SHARAD B	INDIANA
GHATNEKAR, MD, JAI V	ALLEGHENY
GHATNEKAR, MD, REVATI JAI	ALLEGHENY
GHATTAS, MD, JANETTE G	BERKS
GHIA, MD, PRADEEP S	NORTHAMPTON
GHOSH, MD, SURESH C	PHILADELPHIA
GHOSHHAJRA, MD, KALYANMAY	ALLEGHENY
GIACCIA, MD, AMATO	BERKS
GIACOBBE, ROSAMARY	STUDENT
GIACOBBO, MD, JOHN N	PHILADELPHIA
GIACOBBO, DO, KENNETH V	PHILADELPHIA
GIAMBER, MD, SAMUEL R	NORTHAMPTON
GIAMMANCO, DO, PETER P	MONTGOMERY
GIAMMATTEI, MD, FRANK P	DELAWARE
GIAMPOLO, MD, ANTHONY J	SOMERSET
GIANFAGNA, MD, WILLIAM J	SCHUYLKILL
GIANGIULIO, MD, DENNIS J	LEHIGH
GIANNASIO, MD, CHARLES V	PHILADELPHIA
GIANNOPOULOS, MD, PETER H	CHESTER
GIANNOTTO, MD, RICHARD P	WESTMORELAND
GIANNUZZI, MD, ROSANNE F	PHILADELPHIA
GIANVITTORIO, JOY M	STUDENT
GIARDINO, MD, ANGELO P	PHILADELPHIA
GIBBLE, MD, JOAN W	YORK
GIBBLE, MD, LEON W	YORK
GIBBONS, MD, JACQUELYN H	DELAWARE
GIBBONS, MD, RICHARD E	PHILADELPHIA
GIBBONS, MD, ROBERT J	LUZERNE
GIBBONS, MD, WILLIAM P	BLAIR
GIBBS, MD, WINFIELD S	NORTHMBRLAND
GIBNEY, MD, SANDRA M	STUDENT
GIBSON, MD, BARBARA B	PHILADELPHIA
GIBSON, MD, F CLAY	WESTMORELAND
GIBSON, MD, JOSEPH M	LANCASTER
GIBSON, MD, KEITH	MONTOUR
GIBSON, MD, WILLIAM B	DELAWARE
GIBSON, MD, WILLIAM S	ALLEGHENY
GIBSON, MD, WILLIAM S	MONTOUR
GIBSON JR, MD, ROY L	ALLEGHENY
GICK, MD, STEPHEN A	ELK/CAMERON
GIESECKE, MD, SUSAN B	BERKS
GIESSWEIN, MD, PETER	YORK
GIGA, MD, JUDITH P	ALLEGHENY
GILARSKY, MD, BRUCE P	YORK
GILBERT, DO, MAX	PHILADELPHIA
GILBERT, MD, ROBERT P	PHILADELPHIA
GILBERT, MD, STEVEN L	PHILADELPHIA
GILBERT-HILLS, REBECCA D	STUDENT
GILBERTI, MD, FRANK F	ALLEGHENY
GILBERTI, MD, MICHAEL V	ALLEGHENY
GILDAY, MD, FRANK J	PHILADELPHIA
GILDEA, MD, JAMES E	DAUPHIN
GILFILLAN III, MD, A GEORGE	BERKS
GILFORD, MD, LAWRENCE M	CLARION
GILGORE, MD, GARY S	PHILADELPHIA
GILHOOL, JAMES J	STUDENT
GILHOOLEY, MD, MICHAEL G	LACKAWANNA
GILL, MD, DONALD J	PHILADELPHIA
GILL, MD, FRANCES M	PHILADELPHIA
GILL, MD, ROBERT J	PHILADELPHIA
GILL, MD, ROY A	MONTGOMERY
GILLELAND JR, MD, WILLIAM N	ALLEGHENY
GILLEN, MD, GEORGE P	NORTHAMPTON
GILLESPIE, MARCIA A	STUDENT
GILLESPIE, THOMAS L	STUDENT
GILLICK, MD, ALAN P	LACKAWANNA
GILLIGAN, MD, FRANK P	DELAWARE
GILLIO, MD, ROBERT G	LANCASTER
GILLIS, MD, ANGUS T	MONTGOMERY
GILLIS, LYNETTE A	STUDENT
GILLIS, MD, VICTORIA A	INDIANA
GILLMAN, MD, EDWIN C	DAUPHIN
GILLUM, MD, DAVID F	TIOGA
GILLUM, MD, DIANE R	PHILADELPHIA
GILMAN, MD, EDWARD	ALLEGHENY
GILMAN, MD, PAUL B	PHILADELPHIA
GILMORE, MD, DOROTHEA M	CLEARFIELD
GILMORE, MD, FREDERICK R	CLEARFIELD
GILMORE, MD, GEORGE H	ALLEGHENY
GILMORE, MD, JAMES	ALLEGHENY
GILOT, MD, JEAN M	BLAIR
GILROY, MD, ROBERT C	DAUPHIN
GINCHEREAU, MD, EUGENE H	ALLEGHENY
GINGRICH, MD, KERRY H	LEBANON
GINGRICH, MD, KEVIN A	CHESTER
GINGRICH JR, MD, RUSSELL L	LEBANON
GINIECZKI, MD, CHESTER J	PHILADELPHIA
GINSBERG, MD, DAVID K	PHILADELPHIA
GINSBERG, MD, GARY	BERKS
GINSBERG, MD, GENE H	LEHIGH
GINSBERG, DO, PHILLIP C	PHILADELPHIA
GINSBURG, MD, ABRAHAM	PHILADELPHIA
GINSBURG, MD, DAVID S	DELAWARE
GINSBURG, DO, HARRY	PHILADELPHIA
GINSBURG, MD, HOWARD H	PHILADELPHIA
GINSBURG, MD, JOHN L	UNION
GINSBURG, MD, KENNETH R	PHILADELPHIA
GINSBURG, MD, LEONARD H	DELAWARE
GINSBURG, MD, MICHAEL J	ALLEGHENY
GINSBURG, DO, RICHARD E	PHILADELPHIA
GINSBURG, DO, STEVEN M	NORTHAMPTON
GINTER JR, MD, GEORGE C	LYCOMING
GIORDANO, MD, JOSEPH A	MERCER
GIORDANO, MD, NICHOLAS D	LUZERNE
GIORGIO, MD, QUENTIN M	DELAWARE
GIPSON, MD, LAWRENCE L	ALLEGHENY
GIRARDO, MD, SALVATORE P	PHILADELPHIA
GIRDANY, MD, BERTRAM R	ALLEGHENY
GIRDANY, MD, DAVID S	ALLEGHENY
GIRONE, MD, JOSEPH A C	PHILADELPHIA
GIRONE, MD, JOSEPH F	PHILADELPHIA
GIRSH, MD, LEONARD S	PHILADELPHIA
GIRTON, MD, KEITH E	CLINTON
GIRVIGIAN, MICHAEL R	STUDENT
GISH, MD, ROBIN D	LANCASTER
GISLASON, MD, G JOHN	PHILADELPHIA
GITLOW, MD, STUART	ALLEGHENY
GITTELMAN, MD, MICHAEL A	STUDENT
GITTINGS, MD, PAUL E	ALLEGHENY
GITTLEMAN, MD, MARK A	LEHIGH
GITTLEMAN, MD, STANTON C	PHILADELPHIA
GITTLEN, MD, STANFORD D	BUCKS
GIUDICE, MD, VIRGINIO J	PHILADELPHIA
GIUGLIANO, MD, FRANK J	COLUMBIA
GIULIAN, MD, BERTRAND B	DAUPHIN
GIUNTOLI, MD, ROBERT L	PHILADELPHIA
GIURGIU, MD, DAN I N	PHILADELPHIA
GIVEN, MD, KENNETH M	PHILADELPHIA
GIVENS, MD, FREDERICK T	DAUPHIN
GIVENS, MD, KERRY T	LANCASTER
GIVERTZ, ALAN R	STUDENT
GLAD, MD, LAWRENCE J	ALLEGHENY
GLADSTONE, MD, JULIAN L	DELAWARE
GLAH, DO, JAMES J	BEDFORD
GLAH JR, MD, HENRY J	LANCASTER
GLANTZ, MD, ANDREW I	NORTHAMPTON
GLANZBERG, MD, PAULINE	MONTGOMERY
GLASER, MD, ALAN L	ERIE
GLASER, MD, BARRY L	MONTGOMERY
GLASER, JEFFREY B	STUDENT
GLASGOW, MD, STEVEN G	PHILADELPHIA
GLASS, MD, GREGORY L	BEAVER
GLASS, MD, PHILLIP	PHILADELPHIA
GLASS, MD, ROBERTA L	PHILADELPHIA
GLASS, MD, SAMUEL L	CAMBRIA
GLASSBURN, MD, EDWARD M	ALLEGHENY
GLASSBURN, MD, JOHN R	PHILADELPHIA
GLASSER, MD, STUART A	WESTMORELAND
GLASSMAN, MD, JOEL M	PHILADELPHIA
GLASSMAN, MD, SOLOMON	PHILADELPHIA
GLASSNER, MD, MICHAEL J	MONTGOMERY
GLASSO, MD, LOUIS C	ALLEGHENY
GLAUSER, MD, ELINOR M	PHILADELPHIA
GLAUSER, MD, TERRY A	MONTGOMERY
GLAZER, MD, ROBERT M	PHILADELPHIA
GLAZERMAN, MD, LARRY R	LEHIGH
GLEASON, MD, JAMES A	ALLEGHENY
GLEDITSCH, MD, SCOTT D	ALLEGHENY
GLEESON, MD, GEORGE H	ALLEGHENY
GLEESON, MD, GEORGE L	DAUPHIN
GLEESON, MD, MICHAEL F	LACKAWANNA
GLEESON, MD, SEAN P	PHILADELPHIA
GLENNEY, MD, ROBERT J	POTTER
GLESSNER, MD, CAROL A	BERKS
GLICINI, MD, ROBERT L	LUZERNE
GLICK, MD, ABRAHAM	PHILADELPHIA
GLICK, MD, HAROLD M	ALLEGHENY
GLICK, MD, KENNETH A	ALLEGHENY
GLICK, MD, MARK R	DAUPHIN
GLICK, MD, RONALD M	ALLEGHENY
GLICK, MD, SETH N	PHILADELPHIA
GLIELMI, DO, VINCENT D	LANCASTER
GLIKMAN, MD, NADEZHDA	PHILADELPHIA
GLOGER, MD, MARK S	PHILADELPHIA
GLORIOSO, MD, ROBERT C	YORK
GLOSSER, MD, WILLIAM E	BERKS
GLOVER, MD, DONNA J	PHILADELPHIA
GLOWACKI, MD, FRANCIS L	VENANGO
GLUCK, MD, DANIEL S	PHILADELPHIA
GLUCK, MD, JULIE L	ALLEGHENY
GLUCKMAN, MD, ROBERT J	ALLEGHENY
GLUNK, MD, DANIEL J	LYCOMING
GLUNK, MD, RICHARD P	MONTGOMERY
GMUER, MD, PAUL J	ERIE
GNEGY, MD, DAVID A	ALLEGHENY
GNEGY, MD, RICHARD	ALLEGHENY
GO, MD, ALFONZO H L	LYCOMING
GO, MD, JOSEPHINE L	DELAWARE
GO, MD, WELLES P	PHILADELPHIA
GO JR, MD, WILLIAM C	CAMBRIA
GOBEL, MD, REGINALD T	YORK
GOBERN, CARMITA A	STUDENT
GOCHOCO, MD, JACINTO J	YORK
GOCIAL, MD, BENJAMIN	PHILADELPHIA
GODBOUT, MD, BRETT P	NORTHAMPTON
GODDARD JR, MD, JAMES E	LANCASTER
GODFREY, DO, CRAIG R	CRAWFORD
GODFREY, MD, DAVID K	MCKEAN
GODINEZ, MD, RODOLFO I	PHILADELPHIA
GODLA, MD, GREGORY J	ALLEGHENY
GODSHALL, CHRISTOPHER J	STUDENT
GODSHALL, MD, RICHARD W	BUCKS
GODSHALL, MD, STANLEY M	LANCASTER
GODSHALL, STEPHEN E	STUDENT
GOEBERT, MD, HERBERT W	CHESTER
GOEDECKE, MD, JOHN B	DAUPHIN
GOEHRING, MD, DONALD E	BUTLER
GOEHRING, MD, WALTER O	ALLEGHENY
GOEL, MD, AMITABH P	ALLEGHENY
GOEL, MD, ANITA A	ALLEGHENY
GOEL, MD, SANJAY D	PHILADELPHIA
GOELTSCH, MD, ROBERT E	DAUPHIN
GOESER, MD, EUGENE	DELAWARE
GOESSLER, MD, MARY C	ALLEGHENY
GOETZ, MD, KATHARINE M	ALLEGHENY
GOFF, MD, ELIZABETH	LEHIGH
GOFF, MD, SHARON E	CAMBRIA
GOHN, MD, DOUGLAS C	LANCASTER
GOITZ, MD, ROBERT J	ALLEGHENY
GOKALP, MD, NEVIN E	PHILADELPHIA
GOKHALE, MD, SUDHIR B	ERIE
GOLANI, MD, UMESH A	ALLEGHENY
GOLD, MD, ALLAN	PHILADELPHIA
GOLD, MD, BARBARA W	PHILADELPHIA
GOLD, MD, HENRY J	PHILADELPHIA
GOLD, MD, HERMAN	DELAWARE
GOLD, MD, JACK	ERIE
GOLD, MD, JONATHAN	BUCKS
GOLD, MD, MORRIE G	CHESTER
GOLDBACHER, MD, LAWRENCE R	PHILADELPHIA
GOLDBERG, MD, ANDREW L	ALLEGHENY
GOLDBERG, MD, BARRY B	PHILADELPHIA
GOLDBERG, MD, GARY	PHILADELPHIA
GOLDBERG, MD, HARRY	PHILADELPHIA
GOLDBERG, MD, HARVEY E	BUCKS
GOLDBERG, MD, LARRY H	PHILADELPHIA
GOLDBERG, MD, LEE R	PHILADELPHIA
GOLDBERG, MD, LISA A	ALLEGHENY
GOLDBERG, MD, LOUIS	MONTGOMERY
GOLDBERG, MD, MICHAEL E	BUCKS
GOLDBERG, DO, RICHARD A	MONTGOMERY
GOLDBERG, MD, RICHARD E	PHILADELPHIA
GOLDBERG, MD, RICHARD M	MONTOUR
GOLDBERG, MD, RONALD J	DELAWARE
GOLDBERG, MD, SHELDON	PHILADELPHIA
GOLDBERG, MD, STEVEN P	PHILADELPHIA
GOLDBERG, MD, TODD H	PHILADELPHIA
GOLDBERGER, MD, ARNOLD	PHILADELPHIA
GOLDBLATT, MD, CURTIS S	ALLEGHENY
GOLDBLATT, MD, SIDNEY A	CAMBRIA
GOLDBLUM, MD, ABRAHAM D	ALLEGHENY
GOLDBLUM, MD, KENNETH D	CHESTER
GOLDBLUM, MD, LEE J	ALLEGHENY
GOLDBLUM, MD, ORIN M	ALLEGHENY
GOLDBLUM, MD, RAYMOND W	ALLEGHENY
GOLDBURGH, MD, WARREN P	PHILADELPHIA
GOLDEN, MD, GERALD S	PHILADELPHIA
GOLDEN, GIL A	STUDENT
GOLDEN, MD, MANO R	MONTGOMERY
GOLDEN, MD, MICHAEL A	PHILADELPHIA
GOLDEN, MD, MICHAEL F	CHESTER
GOLDEN, THADDEUS W	STUDENT
GOLDENER, MD, JOHN F	MONTGOMERY
GOLDFARB, MD, DANIEL D	LEHIGH
GOLDFARB, MD, HAROLD J	LEHIGH
GOLDFARB, MD, I WILLIAM	ALLEGHENY
GOLDFARB, MD, RICHARD M	BUCKS
GOLDFEDER, MD, WARREN J	WAYNE/PIKE
GOLDFINE, MD, ALAN	CHESTER
GOLDIN, MD, RALPH J	LANCASTER
GOLDING, MD, DANIEL M	PHILADELPHIA
GOLDING, MD, IRVIN M	ALLEGHENY
GOLDMAN, MD, ALLA	BERKS
GOLDMAN, MD, ARTHUR	DELAWARE
GOLDMAN, MD, GARY L	LANCASTER
GOLDMAN, MD, H WARREN	PHILADELPHIA
GOLDMAN, MD, IRVING S	ALLEGHENY
GOLDMAN, MD, MICHAEL S	STUDENT
GOLDMAN, MD, RICHARD J	DELAWARE
GOLDMAN, MD, ROBERT F	FRANKLIN
GOLDMAN, MD, SCOTT M	PHILADELPHIA
GOLDMAN, MD, STANLEY R	DAUPHIN
GOLDMAN, MD, STEPHEN M	PHILADELPHIA
GOLDMAN, MD, STEVEN A	ALLEGHENY
GOLDMAN, MD, WILLIAM J	MONTGOMERY
GOLDMUNTZ, MD, ELIZABETH	PHILADELPHIA
GOLDNER, MD, DAVID B	LEHIGH
GOLDNER, DO, JONATHAN A	MONROE
GOLDSCHMIDT, MD, HERBERT	MONTGOMERY
GOLDSCHMIDT JR, MD, JOSEPH C	DELAWARE
GOLDSMITH, MD, CHARLES P	LEHIGH
GOLDSMITH, MD, JOYCE	PHILADELPHIA
GOLDSTEIN, MD, ALLAN	BERKS
GOLDSTEIN, AMY C	STUDENT
GOLDSTEIN, MD, ARNOLD L	BUCKS
GOLDSTEIN, MD, ARTHUR M	PHILADELPHIA
GOLDSTEIN, MD, BERNARD	PHILADELPHIA
GOLDSTEIN, MD, DAVID M	ALLEGHENY
GOLDSTEIN, MD, ELLIOTT J	ALLEGHENY
GOLDSTEIN, MD, ERROLL J	LUZERNE
GOLDSTEIN, MD, FRANZ	PHILADELPHIA
GOLDSTEIN, MD, HEIDI J	PHILADELPHIA
GOLDSTEIN, MD, JACOB	PHILADELPHIA
GOLDSTEIN, MD, JEROME	PHILADELPHIA
GOLDSTEIN, MD, JEROME B	DELAWARE
GOLDSTEIN, MD, LARRY E	PHILADELPHIA
GOLDSTEIN, MD, MARC F	PHILADELPHIA
GOLDSTEIN, MD, MARK R	DELAWARE
GOLDSTEIN, MICHAEL J	STUDENT
GOLDSTEIN, MD, MORTON L	ALLEGHENY
GOLDSTEIN, MD, NEIL H	CHESTER
GOLDSTEIN, MD, NORMAN A	CHESTER
GOLDSTEIN, MD, PHILIP D	MONTGOMERY
GOLDSTEIN, MD, RICHARD S	BUCKS
GOLDSTEIN, MD, ROBERT C	PHILADELPHIA
GOLDSTEIN, MD, RON Y	PHILADELPHIA
GOLDSTEIN, MD, SCOTT D	PHILADELPHIA
GOLDSTEIN, DO, STEVEN H	PHILADELPHIA
GOLDSTONE, MD, SHELDON B	LACKAWANNA
GOLDSTROHM, MD, GREGG L	WESTMORELAND
GOLDWEIN, MD, MANFRED I	PHILADELPHIA
GOLIO, MD, ANTHONY G	WESTMORELAND
GOLLA, MD, SARASWATHI K	ALLEGHENY
GOLLATZ, MD, JOHN W	ALLEGHENY
GOLTZ, MD, GERALD M	ALLEGHENY
GOMBAR, MD, EDWARD F	LACKAWANNA
GOMBERG, BRUCE F C	STUDENT
GOMBERG, MD, JACK A	PHILADELPHIA
GOMEZ, MD, ANSELMO R	WESTMORELAND
GOMEZ, MD, LUIS L	CRAWFORD
GOMEZ, MD, SOPHIE	ALLEGHENY
GONCZ JR, DO, GRAY	ALLEGHENY
GONICK, MD, PAUL	PHILADELPHIA
GONNELLA, MD, JOSEPH S	PHILADELPHIA
GONSKY, DO, MARK A	LUZERNE
GONZALES, MD, ALBERT	BUCKS
GONZALES, MD, JERRY M	PHILADELPHIA
GONZALEZ, MD, ALEJANDRO R	ALLEGHENY
GONZALEZ, MD, CARLOS F	PHILADELPHIA
GONZALEZ, MD, DIEGO J	YORK
GONZALEZ, MD, JOSE L	SCHUYLKILL
GONZALEZ, MD, LORENZO	MERCER
GONZALEZ, MD, MELCHOR E	MONTGOMERY
GONZALEZ, MD, RENE M	ALLEGHENY
GONZALEZ-FLORIN, MD, RUBEN A	BLAIR
GONZALEZ-MASO, MD, GUILLERONO E	PHILADELPHIA
GOOD, MD, DANIEL C	LANCASTER
GOOD, GARTH M	STUDENT
GOOD, MD, GARY R	DAUPHIN
GOOD, MD, HARRY S	LEHIGH
GOOD, MD, MILTON S	LANCASTER
GOOD, MD, PHILIP K	CENTRE
GOOD, MD, ROBERT P	MONTGOMERY
GOODE JR, MD, JOHN G	PHILADELPHIA
GOODENOW, MD, ELIZABETH L	LYCOMING
GOODISON, SOPHIA M	STUDENT
GOODKIN, MD, MICHAEL B	DELAWARE
GOODMAN, MD, BRUCE	DAUPHIN
GOODMAN, MD, BRUCE A	BUCKS
GOODMAN, MD, CARL R	MONTGOMERY
GOODMAN, MD, DAVID A	YORK
GOODMAN, MD, DAVID A	MONTGOMERY
GOODMAN, MD, DAVID B	FAYETTE
GOODMAN, MD, GEORGE B	ALLEGHENY
GOODMAN, JAY D	STUDENT
GOODMAN, MD, LOWELL I	DELAWARE
GOODMAN, MD, MARK A	ALLEGHENY
GOODMAN, MATTHEW A	STUDENT
GOODMAN, MD, MICHAEL S	BUCKS
GOODMAN, MD, RICHARD A	ALLEGHENY
GOODMAN, MD, SANFORD M	MONTGOMERY
GOODNER, MD, DAVID M	PHILADELPHIA
GOODPASTURE, MD, AUDREY B	DAUPHIN
GOODREAU, MD, JAMES J	LEHIGH
GOODRICH, DO, BRENDA A	MONTGOMERY
GOODRICH, MD, DAVID C	NORTHAMPTON
GOODRICH, MD, JACK K	ERIE
GOODSON, MD, BRUCE M	BERKS
GOODSTEIN, MD, MICHAEL H	YORK
GOODWORTH, MD, JOHN H	ALLEGHENY
GOOLSARRAN, VANESSA J	STUDENT
GOONEWARDENE, SHANTH A	STUDENT
GOPAL, MD, KRISHNAN A	ALLEGHENY
GOPAL, MD, T A	LEHIGH
GOPALANI, MD, AZIZ A	ALLEGHENY
GOPLERUD, MD, ELIZABETH J	CARBON
GOPPELT, MD, JOHN W	MONTGOMERY
GORALCZYK JR, MD, EDWARD J	ALLEGHENY
GORCHESKY, MD, MARK S	BLAIR
GORDEUK, MD, DANIEL S	CENTRE
GORDIAN, MD, MARIA A	PHILADELPHIA
GORDIN, MD, STEPHEN J	PHILADELPHIA
GORDON, ADAM J	STUDENT
GORDON, MD, ALAN D	MIFFLIN/JUNIATA
GORDON, ALEXIA L	STUDENT
GORDON, MD, ANDREW J	ALLEGHENY
GORDON, MD, ARTHUR E	MONTGOMERY
GORDON, MD, CHARLES A	LEHIGH
GORDON, MD, DANIEL J	BERKS
GORDON, DO, DANIEL S	JEFFERSON
GORDON, MD, DAVID A	LEHIGH
GORDON, MD, DUDLEY R	DAUPHIN
GORDON, MD, ELIZABETH H	ALLEGHENY
GORDON, MD, GARY V	MONTGOMERY
GORDON, MD, GERALD	MONTOUR
GORDON, MD, GREGORY R	BUCKS
GORDON, MD, HAROLD E	WESTMORELAND
GORDON, MD, HAROLD M	DELAWARE
GORDON, MD, ISADORE	CHESTER
GORDON, MD, JAMES K	BEDFORD
GORDON, MD, JEROLD S	ALLEGHENY
GORDON, MD, JOSEPH S	DELAWARE
GORDON, MD, LEONARD F	MONTGOMERY
GORDON, MD, MICHAEL E	BERKS
GORDON, MD, MICHAEL J	LEHIGH
GORDON, MD, MILTON S	WESTMORELAND
GORDON, MD, MURRAY B	ALLEGHENY
GORDON, NANCY D	STUDENT
GORDON, PAULA J	STUDENT
GORDON, MD, RICHARD D	BUCKS
GORDON, MD, ROBERT A	DAUPHIN
GORDON, MD, ROBERT H	PHILADELPHIA
GORDON, MD, RODNEY G	ALLEGHENY
GORDON, DO, SANFORD A	WASHINGTON
GORDON, MD, SUSAN J	PHILADELPHIA
GORDON, MD, TOM J	ALLEGHENY
GORDON, MD, WILLIAM S	DAUPHIN
GORDON JR, MD, KENNETH H	MONTGOMERY
GORELICK, MD, MARC H	PHILADELPHIA
GOREN, MD, ELIHU N	MONTGOMERY

GOREN, MD, ROBERT A	PHILADELPHIA
GOREN, MD, RONALD C	PHILADELPHIA
GOREN, MD, STANLEY E	PHILADELPHIA
GORGUI, MD, MAGDY E	ALLEGHENY
GORIN, MD, MICHAEL B	ALLEGHENY
GORMAN, MD, ROBERT C	PHILADELPHIA
GORMAN, MD, SEAN J	PHILADELPHIA
GORMAN-CATTON, MD, JOHANNA H	CHESTER
GORMLEY, MD, ROBERT A	ALLEGHENY
GORTI, MD, SUBBARAO	PHILADELPHIA
GORTON, MD, CHRISTOPHER P	DAUPHIN
GORTYCH-BARNES, MD, VIRGINIA A	MONROE
GOSAI, MD, KAMLESH B	WASHINGTON
GOSFIELD JR, MD, EDWARD	PHILADELPHIA
GOSNELL, MARK S	STUDENT
GOSSETT, JEFFREY G	STUDENT
GOSZTONYI JR, MD, RUDOLPH E	NORTHAMPTON
GOTKIEWICZ, MD, EDWARD M	ALLEGHENY
GOTLIEB, MD, JERRY	MONTGOMERY
GOTTHEIL, MD, EDWARD	PHILADELPHIA
GOTTLIEB, MD, HARRY	PHILADELPHIA
GOTTLIEB, MD, JEROME I	LANCASTER
GOTTLIEB, DO, MARK S	BUCKS
GOTTLIEB, MD, MICHAEL A	ALLEGHENY
GOTTLIEB, MD, PHILIP M	PHILADELPHIA
GOTTLIEB, MD, ROBERT J	LANCASTER
GOTTLIEB, MD, RONALD S	PHILADELPHIA
GOTTLIEB, MD, STANLEY	PHILADELPHIA
GOTTSHALL, MD, SAMUEL C	LACKAWANNA
GOULD, DAVID A	STUDENT
GOULD, MD, RICHARD B	PHILADELPHIA
GOULD, MD, SAM C	LUZERNE
GOULDIN, MD, JUDITH A	LYCOMING
GOULDY, CHRISTINE A	STUDENT
GOULEY, MD, BENJAMIN A	PHILADELPHIA
GOURASH, MD, LEONA	ALLEGHENY
GOUW, MD, CHRISTOPHER B	CARBON
GOVI, MD, MICHAEL J	ALLEGHENY
GOVINDARAO, DINESH	STUDENT
GOWDEY, MD, M AGNES	PHILADELPHIA
GOWEN, MD, GEORGE F	PHILADELPHIA
GOWING, MD, JEAN	PHILADELPHIA
GOYAL, MD, AJAY K	PHILADELPHIA
GOYAL, MD, DEEPI G	ALLEGHENY
GOYAL, MD, MAHEEP K	PHILADELPHIA
GOYNE, MD, RUTH G	DELAWARE
GOZUM, MD, CARMEN Z	NORTHAMPTON
GRAB, MD, EDMUNDO M	BLAIR
GRABAR, MD, JOYCE M	PHILADELPHIA
GRABELSKY, MD, STEPHEN A	PHILADELPHIA
GRABIAK, MD, GREGORY D	WESTMORELAND
GRABIAS, MD, STANLEY L	BERKS
GRABLE, JOHN C	STUDENT
GRABOWSKI, MD, MARIE A	LUZERNE
GRACE, MD, HELEN K	PHILADELPHIA
GRACE, MD, JAMES J	SUSQUEHANNA
GRACEY, MD, JACK G	YORK
GRACEY, VICKIE L	STUDENT
GRAD, MD, CHARLES T	LACKAWANNA
GRADMAN, MD, ALAN H	ALLEGHENY
GRADY, MD, CHRISTOPHER K	PHILADELPHIA
GRADY, MD, PATRICK J	LACKAWANNA
GRAEFFE, MD, ESTELLA F	MONTGOMERY
GRAFF, MD, DANIEL M	ALLEGHENY
GRAFF, MD, HAROLD A	MONTGOMERY
GRAHAM, MD, BARRY E	BERKS
GRAHAM, CAMILLA S	STUDENT
GRAHAM, DO, E JOAN	LUZERNE
GRAHAM, MD, JOHN S	ALLEGHENY
GRAHAM, MD, MARK G	PHILADELPHIA
GRAHAM, MD, NATHANIEL L	MCKEAN
GRAHAM, MD, PATRICIA A	DELAWARE
GRAHAM, MD, THOMAS H	CHESTER
GRAHAM, MD, THOMAS R	ALLEGHENY
GRAHAM, MD, TIMOTHY S	LAWRENCE
GRAHAM III, MD, WILLIAM P	CUMBERLAND
GRANA, MD, PHILIP C	BEDFORD
GRANA, MD, VICENTE P	PHILADELPHIA
GRANADOS, MD, NICANOR G	BERKS
GRANADOS, MD, SUZITA N	BERKS
GRANATO, MD, JEROME E	ALLEGHENY
GRANDIS, MD, DONALD J	ALLEGHENY
GRANDIS, MD, JENNIFER R	ALLEGHENY
GRANDON, MD, RAYMOND C	DAUPHIN
GRANETT, MD, JEFFREY R	DELAWARE
GRANICK, MD, MARK S	PHILADELPHIA
GRANITO, MD, CHARLES D	DAUPHIN
GRANOWITZ, MD, SAMUEL P	ALLEGHENY
GRANSON, MD, MARC A	NORTHAMPTON
GRANT, MD, B DAVID	DELAWARE
GRANT, MD, HOWARD R	CHESTER
GRANT, MD, KATHLEEN J	ALLEGHENY
GRASSI, MD, JOSEPH J	LEHIGH
GRATCH, DO, DAVID M	PHILADELPHIA
GRATCH, MD, MICHAEL J	MONTGOMERY
GRATZ, DO, IRWIN	PHILADELPHIA
GRATZ, MD, RICHARD E	LACKAWANNA
GRAUEL JR, MD, THEODORE A	LAWRENCE
GRAVES, MD, LYNDA C S	SCHUYLKILL
GRAVES, MD, SALINA D	PHILADELPHIA
GRAVES, MD, VAUGHAN C	PHILADELPHIA
GRAVES JR, MD, BEVERLY	PHILADELPHIA
GRAY, MD, CHARLES R	PHILADELPHIA
GRAY, MD, CYNTHIA A	ALLEGHENY
GRAY, MD, DAVID W	UNION
GRAY, MD, FRIEDA G	PHILADELPHIA
GRAY, MD, HERBERT M	BEAVER
GRAY, MD, JERRY L	CAMBRIA
GRAY, MD, LOUIS P	LANCASTER
GRAY, MD, ROBERT T	FRANKLIN
GRAY III, MD, SAMUEL	ALLEGHENY
GRAY JR, MD, FRANK D	PHILADELPHIA
GRAY JR, MD, GEORGE H	ALLEGHENY
GRAYSON, KEVIN D	STUDENT
GRAYSON, MD, MITCHELL H	PHILADELPHIA
GRAYUM, MD, BRADLEY P	DELAWARE
GRAZIANI, MD, VIRGINIA	PHILADELPHIA
GRAZIOSO, MD, HENRY J	PHILADELPHIA
GREALISH, MD, ROBERT J	ALLEGHENY
GREATHOUSE, MD, MARK K	ALLEGHENY
GRECO, DAVID T	STUDENT
GRECO, MD, FRANK D	ALLEGHENY
GRECO, MD, JEFFREY M	NORTHMBRLAND
GRECO, MD, JONATHAN P	DELAWARE
GRECO, MD, ROBERT M	SCHUYLKILL
GRECO, MD, TIMOTHY M	PHILADELPHIA
GRECO, MD, TOBY A	PHILADELPHIA
GRECO, MD, VICTOR F	LUZERNE
GREEN, DO, ALFRED I	PHILADELPHIA
GREEN, MD, BARRY P	MONTGOMERY
GREEN, MD, BRADFORD	BUCKS
GREEN, CANDACE C	STUDENT
GREEN, MD, CHARLES	SCHUYLKILL
GREEN, MD, GEORGE R	MONTGOMERY
GREEN, MD, LAWRENCE	DELAWARE
GREEN, MD, LELAND J	MONTGOMERY
GREEN, MD, M EDWIN	DAUPHIN
GREEN, MD, MAYER A	ALLEGHENY
GREEN, MD, RICHARD L	ALLEGHENY
GREEN, DO, ROBERT L	DAUPHIN
GREEN, MD, ROBERT M	ALLEGHENY
GREEN, MD, ROY	SCHUYLKILL
GREEN, MD, THOMAS J	CUMBERLAND
GREEN, MD, WILLIAM	PHILADELPHIA
GREEN, MD, WILLIAM H	DELAWARE
GREEN III, MD, JOSEPH E	CUMBERLAND
GREEN JR, MD, WILLIAM T	ALLEGHENY
GREENACRE, MD, JUDITH K	PHILADELPHIA
GREENAWALD, MD, HENRY A	DAUPHIN
GREENBARG, MD, JEFFREY B	PHILADELPHIA
GREENBAUM, MD, ARTHUR M	WARREN
GREENBAUM, MD, CHARLES H	PHILADELPHIA
GREENBAUM, MD, JAMES K	ARMSTRONG
GREENBAUM, MD, MARVIN H	MONTGOMERY
GREENBAUM, MD, ROY L	BUCKS
GREENBERG, MD, BRAM	MONTGOMERY
GREENBERG, MD, HOWARD E	MONTGOMERY
GREENBERG, MD, JACK O	PHILADELPHIA
GREENBERG, MD, JAMES A	ALLEGHENY
GREENBERG, JEFFREY	STUDENT
GREENBERG, MD, JONATHAN A	ALLEGHENY
GREENBERG, MD, LEONARD F	PHILADELPHIA
GREENBERG, LINDA W	STUDENT
GREENBERG, MD, MICHAEL J	MONROE
GREENBERG, MD, MICHAEL R	CLINTON
GREENBERG, MD, MYLES D	ALLEGHENY
GREENBERG, MD, RICHARD E	MONTGOMERY
GREENBERG, MD, RICHARD H	PHILADELPHIA
GREENBERG, MD, RICHARD M	PHILADELPHIA
GREENBERG, MD, ROBERT N	BERKS
GREENBERG, MD, STEVEN M	PHILADELPHIA
GREENBERG, MD, STEVEN M	JEFFERSON
GREENBERG, MD, WAYNE V	ALLEGHENY
GREENBERGER, MD, JOEL S	ALLEGHENY
GREENE, MD, DONALD H	LYCOMING
GREENE, GLENN J	STUDENT
GREENE, MD, JEFFREY M	MONTGOMERY
GREENE, MD, JOSEPH S	MONTOUR
GREENE, MD, LUCILLE T	BERKS
GREENE, MD, NEIL A	LANCASTER
GREENE, MD, RICHARD J	BERKS
GREENE, MD, ROBERT F	ALLEGHENY
GREENE, MD, RONALD B	PHILADELPHIA
GREENE, MD, THOMAS E	MONTGOMERY
GREENFIELD, MD, LAWRENCE S	MONTOUR
GREENFIELD, MD, VAL S	PHILADELPHIA
GREENIER, MD, VANESSA R	PHILADELPHIA
GREENLEE, MD, DANIEL P	GREENE
GREENLER, MD, DANIEL P	ALLEGHENY
GREENSMITH, MD, J ERIC	DAUPHIN
GREENSPAN, MD, ALLAN M	PHILADELPHIA
GREENSPAN, MD, BRUCE M	NORTHAMPTON
GREENSPAN, MD, HERBERT S	MONTGOMERY
GREENSPAN, MD, MITCHELL M	BUCKS
GREENSPON, MD, SAMUEL E	MONTGOMERY
GREENWALD, MD, DAVID W	LUZERNE
GREER III, MD, ROBERT B	DAUPHIN
GREGG, MD, GRACE S	ALLEGHENY
GREGG, MD, JOHN R	PHILADELPHIA
GREGG, MD, JOHN S	ALLEGHENY
GREGORY, MD, GEORGE W	BERKS
GREGORY, MD, PETER G	LACKAWANNA
GREGORY, MD, ROBERT E	ALLEGHENY
GREIFER, JONATHAN R	STUDENT
GREIM, MD, CHARLES C	ALLEGHENY
GREINER, MD, ANN S	DAUPHIN
GRESS, MD, FRANCIS A	NORTHAMPTON
GRESS, MD, GORDON A	CAMBRIA
GRESS, MD, JEFFREY P	BUCKS
GRESS, MD, ROBERT E	LANCASTER
GRESS, MD, WILLIAM W	CAMBRIA
GRETH, MD, WARREN E	BERKS
GREY, MD, THADDEUS A	ALLEGHENY
GREYBUSH, MD, JOSEPH N	LEHIGH
GRIBB, MD, JOHN J	BUCKS
GRIBB, MD, JOSEPH C	DAUPHIN
GRIBIK, MD, MICHAEL	ALLEGHENY
GRIEBEL, STEPHEN R	STUDENT
GRIECO, MD, ROBERT L	BEAVER
GRIECO, MD, WILLIAM M	MONTOUR
GRIESMER, MD, PAUL D	LUZERNE
GRIFF, MD, LEONARD C	DAUPHIN
GRIFF, MD, ROBERTA E	DAUPHIN
GRIFFEN, MD, HELEN S	VENANGO
GRIFFEN, MD, R HOWARD	VENANGO
GRIFFEN JR, MD, WARD O	PHILADELPHIA
GRIFFIN, MD, DAVID C	DAUPHIN
GRIFFIN, MD, STEVEN P	INDIANA
GRIFFIN, MD, THOMAS D	PHILADELPHIA
GRIFFIN JR, DO, ROBERT M	NORTHAMPTON
GRIFFITH, MD, ANNETTE Y	BUCKS
GRIFFITH, MD, CHARLES Q	PHILADELPHIA
GRIFFITH, MD, GLENN G	CAMBRIA
GRIFFITH, MD, JOHN R	PHILADELPHIA
GRIFFITHS, JON D	STUDENT
GRILL, MD, HOWARD P	ALLEGHENY
GRILL, MD, WINFRED E	JEFFERSON
GRIM, MD, TRACEY P	YORK
GRIMBERG, MD, ADDA	PHILADELPHIA
GRIMES, MD, CLARENCE W	GREENE
GRIMM, MD, JAMES T	ALLEGHENY
GRINO, MD, BENJAMIN J	PHILADELPHIA
GRIPP, MD, KAREN	PHILADELPHIA
GRISKA, MD, JOEL A	PHILADELPHIA
GROFF, MD, HENRY C	ALLEGHENY
GROFF, DO, JAMES A	DAUPHIN
GROGAN, MD, WENDELL A	PHILADELPHIA
GROH, MD, JOHN R	LEBANON
GROHSMAN, MD, JONATHAN M	MONTGOMERY
GROLEAU, MD, GEORGE E	LANCASTER
GROLMAN, MD, DENNIS M	YORK
GRONKIEWICZ, MD, BRUCE V	CUMBERLAND
GROSH, MD, JOHN L	LANCASTER
GROSH, MD, JOSEPH W	LANCASTER
GROSH, MD, PAUL R	LANCASTER
GROSH, MD, WILLIAM B	LANCASTER
GROSH, MD, WILLIAM K	LANCASTER
GROSKY, MD, MURRAY B	LEBANON
GROSS, MD, BENJAMIN A	PHILADELPHIA
GROSS, MD, DONALD R	YORK
GROSS, GRETTA A	STUDENT
GROSS, MD, LAWRENCE S	BERKS
GROSS, MD, PAUL	ALLEGHENY
GROSS, MD, PAUL R	PHILADELPHIA
GROSSBART, MD, DOUGLAS S	YORK
GROSSBERG, MD, MICHAEL F	FRANKLIN
GROSSINGER, DO, BRUCE H	DELAWARE
GROSSMAN, MD, DAVID	CHESTER
GROSSMAN, MD, GILBERT	PHILADELPHIA
GROSSMAN, MD, I WILLIAM	FAYETTE
GROSSMAN, MD, IRA C	LUZERNE
GROSSMAN, MD, LINDA B	STUDENT
GROSSMAN, MD, STANLEY J	ALLEGHENY
GROTZINGER, MD, MARGARET L	DAUPHIN
GROTZINGER, MD, PAUL J	PHILADELPHIA
GROVE, MD, BRUCE A	YORK
GROVE, MD, GLENN P	YORK
GROVE, MD, RUSSELL E	YORK
GROVE, MD, WILLIAM K	YORK
GROVE JR, MD, DALE A	NORTHAMPTON
GROVER, MD, JOSEPH G	PHILADELPHIA
GROVER, MD, SUKHDEV S	ALLEGHENY
GRUBB, MD, WILLARD Y	BERKS
GRUBBS, MD, ROBERT M	ALLEGHENY
GRUBER, MD, JOHN W	BERKS
GRUEN, MD, GARY S	ALLEGHENY
GRUENBERG, MD, ALAN M	PHILADELPHIA
GRUESEN, DO, MICHAEL J	MONTGOMERY
GRUMET, MD, BERNARD A	ALLEGHENY
GRUNBERG, MD, ROBERT W	NORTHAMPTON
GRUNEWALD, MD, KARL E	PHILADELPHIA
GRUNSTEIN, MD, MICHAEL M	PHILADELPHIA
GRUNT, MD, RICHARD F	PHILADELPHIA
GRUNWALD, MD, JUAN E	PHILADELPHIA
GRUNWALD, MD, ZVI	PHILADELPHIA
GRUZIN, DO, RONALD	BUCKS
GRZESZCZAK, MD, EWA F	DAUPHIN
GRZESZCZAK, MD, MAREK J	DAUPHIN
GSCHWEND III, MD, PAUL	LANCASTER
GUADAGNO, MD, ROBERT C	BEAVER
GUAGLIARDO, DO, JOSEPH P	BUCKS
GUANZON, MD, DANILO L	CRAWFORD
GUARINI, MD, PASQUALE B	DELAWARE
GUARINO, MD, EDWARD F	LEHIGH
GUARINO, MD, JAMES C	PHILADELPHIA
GUARINO, MD, JULIUS M	DELAWARE
GUARNIERI, MD, DAVID M	PHILADELPHIA
GUARNIERI, MD, KATHLEEN M	PHILADELPHIA
GUASTAVINO, MD, THOMAS D	SCHUYLKILL
GUAY JR, MD, ROBERT C	BERKS
GUBERNICK, MD, JULIE A	PHILADELPHIA
GUEHL JR, DO, JOHN J	ALLEGHENY
GUEHL SR, MD, JOHN J	ALLEGHENY
GUELBENZU, MD, NELSON O	CAMBRIA
GUELCHER, MD, ROBERT T	ERIE
GUELIG, MD, EDMUND P	TIOGA
GUENTER, MD, FRITZ E	MCKEAN
GUERGAWI, MARK F	STUDENT
GUERRA, MD, CORAZON A	NORTHAMPTON
GUERRA, MD, REYNALDO C	NORTHAMPTON
GUESON, MD, EMERITA T	PHILADELPHIA
GUEST, DO, DENNIS M	PHILADELPHIA
GUIDONE, MD, PAUL L	MONTGOMERY
GUIE, DO, MARGEL C	FAYETTE
GUILDAY, MD, ROBERT E	DELAWARE
GUILES, STACEY L	STUDENT
GUILLARD, MD, FRANK	CENTRE
GUINTO, MD, JOSE C	ALLEGHENY
GUIRGUES, ASHRAF F	STUDENT
GUIRGUIS, MD, MORRIS F	DELAWARE
GUIRNALDA-CASTRO, MD, NEMESIA G	MONTGOMERY
GUISER, MD, LYNN G	MIFFLIN/JUNIATA
GUISTWITE, MD, KENNETH R	CUMBERLAND
GULATI, MD, AMAR N	MONTGOMERY
GULATI, MD, NEERA	ALLEGHENY
GULICK, MD, THOMAS H	MONROE
GULISH, HEATHER A	STUDENT
GULLOTTI, MD, MICHAEL J	PHILADELPHIA
GULOTTA, MD, PAUL	LEHIGH
GUMEINER, MD, STEVEN C	PHILADELPHIA
GUMERMAN, MD, LEWIS W	ALLEGHENY
GUMINA, MD, THOMAS F	DELAWARE
GUMM, MD, EDWARD A	WESTMORELAND
GUMNIT, MD, ROBERT Y	PHILADELPHIA
GUMP, MD, ROBERT B	ALLEGHENY
GUNDER, MD, SCOTT A	DAUPHIN
GUNDERSON, MD, ROBERT L	LUZERNE
GUNDUZ, MD, PAULA A	ERIE
GUNNERSON, MD, HELENA B	ALLEGHENY
GUNNING, MD, MARY LISA	CHESTER
GUNSTER, MD, GERALD D	LUZERNE
GUNTHER, DAVID M	STUDENT
GUP, MD, DANIEL I	ALLEGHENY
GUPTA, AKASH B	STUDENT
GUPTA, MD, AMITABHA	ALLEGHENY
GUPTA, MD, BABU V	ALLEGHENY
GUPTA, MD, CHITRA L	PHILADELPHIA
GUPTA, MD, DOLLY	PHILADELPHIA
GUPTA, MD, GIRIWARLAL	MONROE
GUPTA, MD, KRISHNA G	WESTMORELAND
GUPTA, MD, NAND K	BUCKS
GUPTA, MD, PRAMILA P	NORTHAMPTON
GUPTA, MD, VED P	PHILADELPHIA
GURGUN, MD, MELIH	ALLEGHENY
GURITZKY, RONALD P	STUDENT
GURMAN, MD, ANDREW W	BLAIR
GURSON, MD, HELEN W	ALLEGHENY
GURUSHANTHAIAH, DEEPAK	STUDENT
GUSA JR, MD, WILLIAM E	BUCKS
GUSTAVSON, MD, ROGER B	DAUPHIN
GUSTILO, M CATHERINE	STUDENT
GUSTIN, MD, THOMAS A	ERIE
GUTEKUNST, MD, PAUL E	PHILADELPHIA
GUTHLEBEN, MD, JOHN G	ERIE
GUTHRIE, MD, WILLIAM J	MONTGOMERY
GUTIERREZ, MD, FELIX	DAUPHIN
GUTMANN, MD, JACQUELINE N	PHILADELPHIA
GUTOWICZ, MD, LORRAINE F	BUCKS
GUTTERMAN, MD, PAUL	LUZERNE
GUTTMAN, MD, MICHAEL	BUCKS
GUTTMANN, MD, GAD G	PHILADELPHIA
GUTTMANN, MD, HARVEY	MONTGOMERY
GUTTMANN, MD, MARLANE C	PHILADELPHIA
GUY, MD, EDWARD B	PHILADELPHIA
GUYER, MD, SAMUEL	MONTGOMERY
GUZEK, MD, JOHN R	LACKAWANNA
GUZZARDO, MD, MICHAEL N	ERIE
GUZZO, MD, JOSEPH C	LEHIGH
GVOZDEN, MD, ROBERT	CAMBRIA
GWIRTZMAN, WENDY G	STUDENT

H

HAACK, MD, SUSAN M	LYCOMING
HAAS, MD, CHARLES M	BLAIR
HAAS, MD, DAVID R	DAUPHIN
HAAS, MD, DONALD D	WESTMORELAND
HAAS, DO, GLENN E	BUCKS
HAAS, JONATHAN C	STUDENT
HAAS, MD, KENT S	PHILADELPHIA
HAASE, MD, GUNTER R	PHILADELPHIA
HAAZ, MD, WILLIAM S	PHILADELPHIA
HABECKER, MD, ELIZABETH T	LEBANON
HABECKER, DO, MELVIN B	LANCASTER
HABER, MD, ARTHUR S	LUZERNE
HABER, MD, BARBARA A	PHILADELPHIA
HABER, MD, HOWARD L	PHILADELPHIA
HABER, MD, MICHELE A	PHILADELPHIA
HABER, MD, SHERYL A	PHILADELPHIA
HADDAD, MD, ROBERT M	MONTOUR
HADDON JR, MD, HARRY H	FRANKLIN
HADFIELD JR, MD, WILLIAM A	DELAWARE
HADRA, MD, ELLINOR S	MONTGOMERY
HAEBERLE, MD, WILLIAM A	PHILADELPHIA
HAEGELE, MD, LINDA A	PHILADELPHIA
HAEUSSNER, MD, CHARLES F	ALLEGHENY
HAFT, MD, HAROLD	PHILADELPHIA
HAGAN JR, MD, EUGENE P	PHILADELPHIA
HAGARTY, MD, JOHN J	MONTGOMERY
HAGBERG, MD, MARGARET M	ALLEGHENY
HAGBERG, MD, WILLIAM C	ALLEGHENY
HAGERTY, MD, FRED D	YORK
HAGES, MD, FOSTER	BEAVER
HAGEY, DO, DEBORAH A	LANCASTER
HAGGARD, MD, ROBERT A	LEBANON
HAGGERTY, MD, ROBERT W	DELAWARE
HAGGERTY, MD, SALLY M	NORTHAMPTON
HAGSTROM, MD, NATHAN	PHILADELPHIA
HAHM, MD, JEE HO	PHILADELPHIA
HAHN, MD, ADAM W	ALLEGHENY
HAHN, MD, GREGORY V	PHILADELPHIA
HAHN, MD, JEANNINE R	CHESTER
HAHN, MD, JONATHAN F	UNION
HAHN, MD, KON S	WAYNE/PIKE
HAHN, MD, RICHARD M	WASHINGTON
HAIBACH, MD, RAYMOND A	ERIE
HAIDER, MD, SYED H	PHILADELPHIA
HAIDET, MD, KEITH R	DAUPHIN
HAIGHT, MD, JOEL B	CENTRE
HAIGHT, MD, RANDALL D	DAUPHIN

HAILS, MD, KEVIN C	PHILADELPHIA
HAIMOWITZ, MD, DANIEL	BUCKS
HAIMOWITZ, MD, JULIA E	PHILADELPHIA
HAIMOWITZ, MD, SAMUEL I	PHILADELPHIA
HAIN, MD, HOWARD L	NORTHAMPTON
HAITH JR, MD, LINWOOD R	DELAWARE
HAJDENBERG, MD, JULIO J	PHILADELPHIA
HAKALA, MD, THOMAS R	ALLEGHENY
HAKAS, MD, JOSEPH F	ALLEGHENY
HAKAS JR, MD, JOSEPH F	ALLEGHENY
HAKE, MD, JEAN H	DAUPHIN
HAKIM, MD, CHRISTIANE M	ALLEGHENY
HALASZYNSKI, MD, LORI M	ALLEGHENY
HALBERT, MD, DAVID R	DAUPHIN
HALCOVAGE, DO, JOHN S	DAUPHIN
HALE, MD, DANIEL E	PHILADELPHIA
HALE, MD, EDWARD H	ALLEGHENY
HALE, DO, RICHARD C	CENTRE
HALE, MD, ROBERT G	MONTGOMERY
HALE, MD, ROBERT H	BUCKS
HALE, MD, THOMAS K	SCHUYLKILL
HALE JR, MD, RAYMOND M	ADAMS
HALENDA, MD, GREGORY	ALLEGHENY
HALL, MD, DANIEL A	PHILADELPHIA
HALL, MD, DAVID G	ALLEGHENY
HALL, MD, DONALD T	LEHIGH
HALL, MD, EDGAR M	CHESTER
HALL, MD, GRAVES S	YORK
HALL, MD, JAMES P	BLAIR
HALL, MD, JOHN H	PHILADELPHIA
HALL, MD, NEAL E	MONTGOMERY
HALL, MD, PATRICK J	PHILADELPHIA
HALL, MD, RICHARD N	ERIE
HALL, MD, ROBERT A	PHILADELPHIA
HALL, MD, ROBERT H	PHILADELPHIA
HALL, MD, ROBERT L	CENTRE
HALL, MD, ROBERT L	DELAWARE
HALL, MD, ROBERT M	CENTRE
HALL, MD, VIRGINIA E	DAUPHIN
HALL II, MD, ROBERT F	CUMBERLAND
HALL JR, MD, JOHN H	WASHINGTON
HALLAHAN, MD, WILLIAM F	LEBANON
HALLERMEIER JR, MD, ROBERT G	DELAWARE
HALLETT, MD, JOSEPH W	PHILADELPHIA
HALLMARK, MD, KAREN H	ALLEGHENY
HALLOCK, MD, GEOFFREY	LEHIGH
HALLOCK, MD, MARGARET E	DAUPHIN
HALLOCK, MD, RICHARD H	DAUPHIN
HALLOWELL, MD, MICHAEL J	PHILADELPHIA
HALMI, MD, BILL H	MONTGOMERY
HALPERIN, MD, MEYER A	MONROE
HALPERN, MD, BARRY R	PHILADELPHIA
HALPERN, MD, BARTON L	LANCASTER
HALPERN, MD, JANIS S	BUCKS
HAM, MD, JAMES W	VENANGO
HAM, MD, TONG H	MERCER
HAMADANI, MD, HOUSHANG G	LEHIGH
HAMANN, MD, JOSE G	PHILADELPHIA
HAMATY, MD, RONALD M	CAMBRIA
HAMBURG, MD, ALLEN E	MONTGOMERY
HAMIDI, MD, JAFAR A	MCKEAN
HAMILTON, CLIO A	STUDENT
HAMILTON, MD, GERALDINE E	DELAWARE
HAMILTON, MD, RALPH W	PHILADELPHIA
HAMILTON, MD, ROBERT W	ALLEGHENY
HAMILTON, MD, ROBERT W	DAUPHIN
HAMILTON, MD, WILLIAM C	PHILADELPHIA
HAMILTON, MD, WILLIAM L	PHILADELPHIA
HAMM, MD, CHARLES R	ALLEGHENY
HAMM, MD, GLENN G	VENANGO
HAMM, MD, WILLIAM G	LYCOMING
HAMME, MD, ELMER G	YORK
HAMMELL, MD, EUGENE J	ALLEGHENY
HAMMETT, MD, JAMES H	ADAMS
HAMMOD, MD, RIYADH S	BUCKS
HAMMOND, MD, CHARLES P	LANCASTER
HAMMOND III, MD, N LEROY	MONTGOMERY
HAMOY, MD, ALICE G	LYCOMING
HAMOY, MD, GEORGE L	LYCOMING
HAMPE, MD, WARREN W	MONTGOMERY
HAMPSEY, MD, JOHN A	NORTHAMPTON
HAMPTON, MD, JANET A	PHILADELPHIA
HAMPTON, MD, LOUIS J	YORK
HAMPTON, REGINA M	STUDENT
HAMSHER, MD, JAMES R	DAUPHIN
HAMZAVI, MD, SIAMAK	LACKAWANNA
HAN, MD, AARON C	PHILADELPHIA
HAN, MD, DALSOO	ALLEGHENY
HAN, MD, PAUL K J	ALLEGHENY
HAN, MD, SAMUEL I	BUTLER
HAN, MD, SUM K	ALLEGHENY
HAN, MD, SUN TAK	LACKAWANNA
HAN, WON K	STUDENT
HAN, MD, YOONG O	ALLEGHENY
HANAU, MD, CHERYL A	PHILADELPHIA
HANAWAY, MD, ANDREA S	PHILADELPHIA
HANBY JR, MD, W FORWOOD E	MONTGOMERY
HANCHETT, MD, JAMES E	ALLEGHENY
HANCOCK, MD, REGINALD A	ALLEGHENY
HAND, MD, ROY H	MONTGOMERY
HANDELMAN, MD, WILLIAM N	BRADFORD
HANDELSMAN, MD, GORDON L	ALLEGHENY
HANDELSMAN, MD, OLIVER	ALLEGHENY
HANDFORD, MD, H ALLEN	DAUPHIN
HANDLER, MD, HARLAN B	ALLEGHENY
HANDLER, MD, IRA S	BUTLER
HANDLER, MD, LAWRENCE F	PHILADELPHIA
HANDLER, MD, STEVEN D	PHILADELPHIA
HANES, MD, MARYANN	PHILADELPHIA
HANES, MD, ROBERT B	DELAWARE
HANHAUSEN JR, MD, EDWARD H	MONTGOMERY
HANISEK, MD, WILLIAM F	NORTHAMPTON
HANJANI, MD, PARVIZ	PHILADELPHIA
HANKEY, MD, JOHN C	ALLEGHENY
HANKINS, MD, ALTHEA	PHILADELPHIA
HANKS, MD, GERALD E	PHILADELPHIA
HANLEY, DO, PATRICK J	LEHIGH
HANLON, MD, JAMES T	ALLEGHENY
HANLON, MD, THOMAS W	LUZERNE
HANNA, MD, DWIGHT C	ALLEGHENY
HANNA, MD, EZZAT A	BERKS
HANNA, MD, HERBERT L	INDIANA
HANNA, DO, MARK J	ALLEGHENY
HANNA, NADINE B	STUDENT
HANNA, MD, ROBERT H	CHESTER
HANNA, MD, SALAH G	WESTMORELAND
HANNO, MD, PHILIP M	PHILADELPHIA
HANNUM, MD, CHRISTOPHER F	DELAWARE
HANNUSH, MD, SADEER B	BUCKS
HANRAHAN, MD, JAMES B	ALLEGHENY
HANSEN, MD, CARL A	BUCKS
HANSEN, HILARY A	STUDENT
HANSPAL, MD, NAVJOT S	CHESTER
HANSPAL, MD, REENA K	CHESTER
HANSROTE, MD, LOUIS W	LEHIGH
HANZEL, MD, GEORGE D	CAMBRIA
HAPPEL, MD, JOHN L	ALLEGHENY
HAPPEL JR, MD, JOHN L	ALLEGHENY
HAQUE, MD, ASMA	DAUPHIN
HARADA, MD, WILLIAM A	NORTHAMPTON
HARADIN, MD, ANTHONY R	ALLEGHENY
HARASYM, MD, E LAWRENCE	COLUMBIA
HARASYM, MD, EUGENE D	LACKAWANNA
HARBACH, MD, HARRISON F	ADAMS
HARBERGER, MD, JAMES H	YORK
HARBISON, MD, SEAN P	PHILADELPHIA
HARCHELROAD JR, MD, FRED P	ALLEGHENY
HARDAS, MD, ANURADHA D	DELAWARE
HARDAWAY, MD, ALFRED E	LYCOMING
HARDEE-CUTHBERT, MD, KAY	MONTGOMERY
HARDEN, MD, MIRIAM R	PHILADELPHIA
HARDEN III, MD, WESLEY R	YORK
HARDENBROOK, MITCHELL A	STUDENT
HARDESTY, MD, JAMES L	HUNTINGDON
HARDESTY, MD, LARA A	DAUPHIN
HARDING, MD, JOHN A	PHILADELPHIA
HARDY, MD, CHARLES A	BUCKS
HARDY, MD, HEIDRUN D	ERIE
HARDY, MD, JOHN C	LEBANON
HARE, MD, JEFFREY D	NORTHAMPTON
HARE, MD, JEFFREY L	BERKS
HAREN, MD, WILLIAM E	FRANKLIN
HARGEST JR, MD, THOMAS E	YORK
HARGLEROAD II, MD, JOHN A	CENTRE
HARGRAVE, MD, HUGH J	LANCASTER
HARGROVE III, MD, WALTER C	PHILADELPHIA
HARIADI, JOHN W	STUDENT
HARIHARAN, MD, SUBRAMANIAN	PHILADELPHIA
HARINSTEIN, MD, DAVID A	ALLEGHENY
HARKAVY, MD, SANDRA E	DELAWARE
HARKER, MD, RICHARD C	LANCASTER
HARKER, EXEC SEC, MARJORIE E	BLAIR
HARKINS, GERALD J	STUDENT
HARKINS, MD, HERBERT P	PHILADELPHIA
HARKINS, MD, PATRICIA M	ALLEGHENY
HARKINS, MD, ROBERT S	SCHUYLKILL
HARKNESS, MD, MICHAEL J	CHESTER
HARLAN, MD, WILLIAM K	NORTHAMPTON
HARLEY, MD, BARBARA M	ALLEGHENY
HARLEY, MD, JOHN B	CAMBRIA
HARM JR, MD, KENNETH R	DAUPHIN
HARMAN, MD, SCOTT M	MONTGOMERY
HARMATZ, MD, ALEXANDER J	PHILADELPHIA
HARMELIN, DO, MICHAEL C	BERKS
HARMON, MD, CARROLL M	PHILADELPHIA
HARMON, MD, ELI B	MONTGOMERY
HARMON-WEISS, MD, SANDRA	MONTGOMERY
HARNED, MD, E MICHAEL	PHILADELPHIA
HARNER, MD, CHRISTOPHER D	ALLEGHENY
HARNER, MD, JEFFREY D	YORK
HARNISH, MD, DAVID M	LANCASTER
HARNIST, MD, KIMBERLY S	ALLEGHENY
HARNLY, MD, NEAL S	LANCASTER
HARP, MD, JAMES R	PHILADELPHIA
HARPER, DEIRDRE W	STUDENT
HARPER, MD, JOHN J	ALLEGHENY
HARPER, MD, STEVEN G	MONTGOMERY
HARPER, SUSAN J	STUDENT
HARR, MD, DENISE F	STUDENT
HARR, MD, DOUGLAS P	BUCKS
HARRER JR, MD, WILLIAM J	MERCER
HARRIGER, MD, MILES D	LANCASTER
HARRING, MD, MAYNARD	SCHUYLKILL
HARRIS, MD, ALBIN W	FRANKLIN
HARRIS, MD, ANNE E	ALLEGHENY
HARRIS, MD, ARTHUR D	PHILADELPHIA
HARRIS, MD, BARRY C	ALLEGHENY
HARRIS, MD, BERNADETTE G	ALLEGHENY
HARRIS, MD, BRIAN W	DAUPHIN
HARRIS, MD, DAVID T	PHILADELPHIA
HARRIS, MD, ESTHER R	PHILADELPHIA
HARRIS, HUGH R	STUDENT
HARRIS, MD, JAMES S	PHILADELPHIA
HARRIS, MD, KATHLEEN M	ALLEGHENY
HARRIS, MD, KENNETH H	PHILADELPHIA
HARRIS, MD, KEVIN R	MONTGOMERY
HARRIS, MD, LAWRENCE K	BERKS
HARRIS, MD, MALCOLM S	ALLEGHENY
HARRIS, DO, MARK R	CHESTER
HARRIS, MD, MARY C	PHILADELPHIA
HARRIS, MD, MERLEEN	PHILADELPHIA
HARRIS, MD, RICHARD N	ALLEGHENY
HARRIS, MD, RONALD I	LUZERNE
HARRIS, MD, STANLEY R	LEHIGH
HARRIS, MD, STEVEN P	ALLEGHENY
HARRISON, MD, ANTHONY M	ALLEGHENY
HARRISON, MD, BERNARD M	BUCKS
HARRISON, MD, BRETT M	BUCKS
HARRISON, MD, DIANE D	BERKS
HARRISON, MD, DREW S	LEHIGH
HARRISON, MD, FRANK D	WESTMORELAND
HARRISON, DO, KEITH W	MONTGOMERY
HARRISON JR, MD, JOSEPH	MONTGOMERY
HARROP, MD, DONALD E	CHESTER
HARRY, MD, HARRIET M	CENTRE
HARSTER, MD, GERALD A	WESTMORELAND
HART, MD, ALEX D	NORTHAMPTON
HART, MD, GEORGE R	LAWRENCE
HART, MD, JAMES C	DAUPHIN
HART, MD, NEIL J	ALLEGHENY
HART, MD, PHILIP L	FAYETTE
HART, DO, WILLIAM J	DELAWARE
HARTENBAUM, MD, DAVID	BUCKS
HARTENBAUM, MD, NATALIE P	BUCKS
HARTER, MD, SCOTT C	MONTOUR
HARTLE, MD, JOHN E	BEDFORD
HARTLEY, MD, PAUL A	FAYETTE
HARTMAN, MD, CHARLES E	YORK
HARTMAN, MD, DOROTHY I S	LEHIGH
HARTMAN, MD, H KING	WESTMORELAND
HARTMAN, MD, OWEN W	FRANKLIN
HARTMAN, DO, STUART A	LEBANON
HARTMAN, MD, WILLIAM F	LANCASTER
HARTMAN II, MD, SAMUEL A	LEBANON
HARTMAN JR, MD, H KING	ALLEGHENY
HARTMANN, MD, DAVID B	ALLEGHENY
HARTNETT, MD, ROBERT W	CAMBRIA
HARTSOCK, MD, ROBERT J	ALLEGHENY
HARTY, MD, MARY P	PHILADELPHIA
HARTZ, MD, LEO M	LYCOMING
HARTZ, MD, WILLIAM H	PHILADELPHIA
HARTZ-SOLOFF, MD, CYNTHIA H	ALLEGHENY
HARTZELL, MD, DAVID L	CUMBERLAND
HARTZELL, KATHLEEN N	STUDENT
HARTZELL JR, MD, GEORGE W	LEHIGH
HARVEY, DO, CHARLES J	BLAIR
HARVEY, MD, EDITH E	PHILADELPHIA
HARVEY, MD, GREGORY D	NORTHAMPTON
HARVEY, MD, JAMES S	CENTRE
HARVEY, MD, KENNETH L	LEHIGH
HARVEY, ROBERT T	STUDENT
HARVEY, MD, WILLIAM J	ALLEGHENY
HARVEY JR, MD, BENSON	LEBANON
HARWICK, MD, JEAN C	ALLEGHENY
HARWICK, MD, JOHN D	LEHIGH
HARWICK, MD, ROBERT D	PHILADELPHIA
HARWOOD, MARC I	STUDENT
HASABNIS, MD, SUHAS P	BLAIR
HASAN, MD, KAMAL S I	JEFFERSON
HASAN, MD, MOHAMMAD A	SCHUYLKILL
HASBACH, MD, THOMAS J	ALLEGHENY
HASELHUHN, MD, DONALD H	DAUPHIN
HASER, MD, HEYWOOD A	ALLEGHENY
HASHIDA, MD, YOSHIE	ALLEGHENY
HASHIN, MD, KIMBERLY A	DAUPHIN
HASHMI, MD, MAJID A	ALLEGHENY
HASIUK, MD, AARON S	BUCKS
HASKIN, MD, MYRA R	MONTGOMERY
HASLEY, MD, STEPHEN K	ALLEGHENY
HASSAN, MD, JOSEPH R	BERKS
HASSEL, MD, JEFFREY L	BERKS
HASSEL, MD, MARK H	LANCASTER
HASSEL JR, MD, CARL W	LANCASTER
HASSEY, MD, JOSEPH A	PHILADELPHIA
HASSINGER, MD, KATHRYN K	YORK
HASSLACHER, MD, ELISABETH A	PHILADELPHIA
HASSLER, MD, CARL W	BERKS
HASSMAN, DO, DAVID R	PHILADELPHIA
HASSOURI, MD, HASSAN	ALLEGHENY
HASTINGS JR, MD, LEO J	LEHIGH
HASZ, MD, RICHARD D	DAUPHIN
HATCHER, MD, KIM A	INDIANA
HATLEBERG, MD, STEVEN L	CUMBERLAND
HATTI, MD, SHIVKUMAR S	DELAWARE
HATTON, MD, DUNCAN S	DELAWARE
HATTOUM, MD, PITTAGORE	WESTMORELAND
HAUER, MD, MARLIN L	LEBANON
HAUGER, MD, HAROLD N	WESTMORELAND
HAUGER, MD, WILLIAM D	CAMBRIA
HAUGHEY, MD, ROBERT E	DELAWARE
HAUN, MD, JOHN P	LANCASTER
HAUPT, DANIELE	STUDENT
HAUPT, MD, DONALD N	MONTGOMERY
HAUPT, MD, GEORGE J	PHILADELPHIA
HAUPT, MD, HELEN M	PHILADELPHIA
HAUPT, MD, RICHARD M	DELAWARE
HAUS, MD, MARY M	WESTMORELAND
HAUS, MD, WILLIAM	ALLEGHENY
HAUSCH, MD, RAYMOND C	MONTOUR
HAUSER, MD, ADAM C	DELAWARE
HAUSER, MD, JOHN R	WASHINGTON
HAUSER, MD, NORMAN	MONTGOMERY
HAUSER, MD, RAYMOND J	BERKS
HAUT, ELLIOTT R	STUDENT
HAUT, MD, MICHAEL J	PHILADELPHIA
HAUT, MD, MITCHELL	ALLEGHENY
HAVER, MD, PAUL M	BEAVER
HAVKO, MD, FREDERICK C	YORK
HAVRILLA, MD, THOMAS R	ALLEGHENY
HAWK, MD, BRAINARD O	ALLEGHENY
HAWK, MD, DAVID L	YORK
HAWKE, MD, WILLIAM	BERKS
HAWKINS, MD, JAMES G	ALLEGHENY
HAWKINS, MD, ROGER A	MERCER
HAWLEY, MD, RICHARD C	SCHUYLKILL
HAWLEY, MD, TONI A	LEHIGH
HAWN, MD, MARGARET M	DAUPHIN
HAWORTH, MD, CHARLES S	BUTLER
HAWRYLUK, MD, OREST	PHILADELPHIA
HAWTOF, JEFFREY E	STUDENT
HAY, MD, ANDY	JEFFERSON
HAY, BEVERLY N	STUDENT
HAY, MD, HAROLD S	SOMERSET
HAYASHI, MD, T TERRY	ALLEGHENY
HAYDEL, MD, MICELLE J	ALLEGHENY
HAYDEN, MD, JAMES B	HUNTINGDON
HAYES, MD, BRIAN L	PHILADELPHIA
HAYES, MD, JAMES C	ALLEGHENY
HAYES, MD, MERRILL B	DELAWARE
HAYES, MD, WARREN H	LYCOMING
HAYES SR, MD, PHILLIP W	PHILADELPHIA
HAYMAN, MD, HARRIS R	CHESTER
HAYMAN, MD, HARRY B	BUCKS
HAYNICZ, MD, PETER	MONROE
HAYTHORNTHWAITE, MD, B MARY	MONTGOMERY
HAYWOOD, MD, MICHELE T	STUDENT
HAZEL, MD, ELIZABETH W	ALLEGHENY
HAZLETT, MD, JANE	LUZERNE
HAZLETT, MD, NANCY S	ALLEGHENY
HAZLETT, MD, WILLIAM H	LUZERNE
HAZLETT JR, MD, WALTER S	WESTMORELAND
HAZZOURI, MD, MICHELE A	LACKAWANNA
HEADLEY, MD, CHAUNCEY R	WASHINGTON
HEANEY, MD, STEVEN J	CRAWFORD
HEAPS, MD, KENNETH P	YORK
HEASLETT, MD, ANN M	PHILADELPHIA
HEATH, MD, F RICHARD	ALLEGHENY
HEATH, MD, KIMBERLY A	STUDENT
HEBDA, MD, WILLIAM B	ARMSTRONG
HEBEL, MD, JEANETTE L	LANCASTER
HEBERLE, DO, PAUL W	STUDENT
HEBRA, MD, ANDRE	PHILADELPHIA
HEBRANK, MD, GREGORY T	WESTMORELAND
HECHT, TODD E	STUDENT
HECHT, MD, WARREN B	MONTGOMERY
HECK, MD, ALBERT W	DAUPHIN
HECK, MD, HARRY J	ALLEGHENY
HECK III, MD, HARRY J	ALLEGHENY
HECKER, MD, LANNY I	ALLEGHENY
HECKER, MD, WILLIAM P	PHILADELPHIA
HECKLER, MD, FREDERICK R	ALLEGHENY
HEDGEPETH, CHESTER M	STUDENT
HEDLUND, DO, TIMOTHY L	BEAVER
HEDRICK, MD, G WINFIELD	BUCKS
HEDRICK, MD, THOMAS A	CAMBRIA
HEERE, MD, BARBARA A	LYCOMING
HEFFERN, MD, JAMES E	LANCASTER
HEFFERNAN, MD, ANDREW H	LEHIGH
HEFFERNAN, MD, J MICHAEL	BERKS
HEFFLER, MD, KAREN F	PHILADELPHIA
HEFFLEY, MD, WILLIAM M	DAUPHIN
HEFFLIN, MD, BROCKTON	ALLEGHENY
HEFFLIN, MD, CHARLES M	ALLEGHENY
HEFFNER JR, MD, GEORGE W	SCHUYLKILL
HEFLIN, MD, DANIEL W	LYCOMING
HEGARTY, MD, FRANCIS A	ALLEGHENY
HEGARTY, JOSEPH C	STUDENT
HEHER, MD, KATRINKA L	PHILADELPHIA
HEID, MD, CHARLES E	UNION
HEIDEN, MD, RICHARD A	BERKS
HEIDENREICH, MD, FRED P	ALLEGHENY
HEIDENREICH, MD, H VINCENT	ALLEGHENY
HEIDERSCHEIDT, BENEDICT G	STUDENT
HEIL, BRIAN V	STUDENT
HEIL, KURT M	STUDENT
HEILBRUNN, MD, STEVEN M	ALLEGHENY
HEILIGMAN, MD, NATHAN H	LEHIGH
HEILMAN, MD, J DANIEL	ALLEGHENY
HEILMANN, MD, TIMOTHY M	LYCOMING
HEIM, MD, WILLIAM J	LACKAWANNA
HEIMBACH, MD, GEORGE Z	NORTHAMPTON
HEIMBACH, MD, JAMES A	BLAIR
HEIMER, MD, JEFFREY L	CENTRE
HEIN, MD, EDWARD W	BERKS
HEIN, MD, JEFFREY P	ERIE
HEINBACH, MD, ROBERT A	NORTHUMBRLAND
HEINE, MD, MARILYN J	BUCKS
HEINE, DO, MARTIN K	FRANKLIN
HEINE, MD, WILLIAM I	PHILADELPHIA
HEINILE, MD, MICHAEL S	BEAVER
HEINILE JR, MD, EDWARD W	BEAVER
HEINLE JR, MD, FREDERICK J	LANCASTER
HEINTZ, MD, JAMES J	LUZERNE
HEIRD, MD, STEVEN B	YORK
HEISE, MD, MICHAEL J	ALLEGHENY
HEISER, MD, MARK S	PHILADELPHIA
HEISEY, MD, JOHN C	BERKS
HEISEY, MD, ROBERT G	LEBANON
HEISTAND, MD, LANDIS C	SCHUYLKILL
HEISTERKAMP III, MD, CHARLES A	LANCASTER
HEIT, MD, JEFFREY	PHILADELPHIA
HEITMANN, MD, DEBRA W	STUDENT
HEKLER, MD, EMILIAN M	BERKS
HELFFRICH, MD, RICHARD S	BLAIR

HELINEK, MD, GERARD L	BERKS
HELINEK, MD, THOMAS G	BERKS
HELLER, MD, ALVIN G	MONTGOMERY
HELLER, MD, FREDERICKA S M	BERKS
HELLER, MD, MELVIN S	PHILADELPHIA
HELLERSTEDT, BETH A	STUDENT
HELLMAN, MD, ARTHUR A	PHILADELPHIA
HELLMANN, JOSEPH R	STUDENT
HELM, MD, ROBERT C	LANCASTER
HELM JR, MD, JOHN D	LANCASTER
HELMICK, MD, NATHANIEL D	MONROE
HELMICK, MD, WAYNE W	BEAVER
HELSING, MD, WALTER J	BEAVER
HELWIG JR, MD, JOHN	PHILADELPHIA
HELY, MD, DANIEL P	CUMBERLAND
HELZNER, MD, EILEEN C	BUCKS
HEMLER, MD, PAUL M	DAUPHIN
HEMLEY, MD, SUSAN R	NORTHAMPTON
HEMMERLY, MD, WILLIAM C	NORTHAMPTON
HEMPHILL, MD, RICHARD W	ALLEGHENY
HENDERSON, MD, K WAYNE	LYCOMING
HENDERSON, DO, MARYANNE J	ALLEGHENY
HENDLER, MD, BARRY H	PHILADELPHIA
HENDREN, MD, WILLIAM G	PHILADELPHIA
HENDRICKS, MD, ROBERT T	CRAWFORD
HENDRICKS JR, MD, GILBERT L	CENTRE
HENDRICKSON, MD, CLIFFORD D	MONTGOMERY
HENDRICKSON, MD, DONALD C	FRANKLIN
HENDRICKSON, MD, JAY A	DELAWARE
HENDRZAK, MD, ANDREA J	STUDENT
HENKEN, DO, HOWARD B	DAUPHIN
HENNESSEY, MD, DAVID H	ALLEGHENY
HENNESSEY, MD, JOSEPH F	MONTGOMERY
HENNESSEY, MD, MICHAEL S	ERIE
HENNIGAN, SHAWN P	STUDENT
HENNING III, MD, GEORGE F	SUSQUEHANNA
HENNINGER, MD, WILLIAM H	BERKS
HENNON, MD, DON L	ALLEGHENY
HENNON, MD, ROBERT P	ALLEGHENY
HENRETIG, MD, FREDERICK M	PHILADELPHIA
HENRIKSEN, MD, DANIEL S	YORK
HENRIKSEN, MD, SUSAN A	YORK
HENRIQUES, MD, ERROL D	CAMBRIA
HENRIQUEZ, MD, LILIANA C	LEHIGH
HENRY, MD, JOHN M	PHILADELPHIA
HENRY, MD, LELAND T	ARMSTRONG
HENRY, MD, MARK R	YORK
HENRY, MD, SCOTT P	ERIE
HENRY, MD, STEPHEN J	DELAWARE
HENRY JR, MD, EDGAR S	ALLEGHENY
HENRY JR, MD, LELAND T	ALLEGHENY
HENSCHEL, KENNETH A	STUDENT
HENSLEY, MD, FREDERICK A	DAUPHIN
HENTOSH, MD, JOHN P	LEHIGH
HENWOOD, DO, CAROL L	CHESTER
HENZES, MD, JACK	LACKAWANNA
HEPLER-SMITH, MD, MICHAEL	ALLEGHENY
HEPPNER, MD, BRADLEY T	ALLEGHENY
HEPPNER, MD, RICHARD L	ALLEGHENY
HERALD, MD, GEOFFREY R	BEAVER
HERB, DO, RONALD K	BERKS
HERBERT, DO, REX A	DAUPHIN
HERBERT, MD, VICKI L	ALLEGHENY
HERBERT, DO, WILLIAM J	MERCER
HERBICK, MD, WILLIAM T	CAMBRIA
HERBISON, MD, GERALD J	PHILADELPHIA
HERBST, MD, ALLISON B	PHILADELPHIA
HERBST, MD, BERNADETTE A	PHILADELPHIA
HERBST, MD, CHARLES G	ERIE
HERCEG, MD, STEPHEN J	DAUPHIN
HERLICH, MD, ANDREW	ALLEGHENY
HERLING, MD, PATTI J	MONTGOMERY
HERMAN, MD, CARL D	PHILADELPHIA
HERMAN, MD, HAROLD	PHILADELPHIA
HERMAN, MD, JAMES M	DAUPHIN
HERMAN, MD, JAY B	ALLEGHENY
HERMAN, MD, JERRY H	PHILADELPHIA
HERMAN, MD, LEONARD Y	PHILADELPHIA
HERMAN, MD, ROMAN K	NORTHAMPTON
HERMAN, MD, RONALD J	YORK
HERMAN, MD, WALTER M	PHILADELPHIA
HERMANN, MD, CHRISTOPHER P	BUCKS
HERMANN, JEFF W	STUDENT
HERMANN, MD, MARY E	COLUMBIA
HERMANOVICH JR, MD, JOHN	BERKS
HERMANY, DO, DEBRA K	SCHUYLKILL
HERMANY, MD, PAUL R	BUCKS
HERNANDEZ, MD, ENRIQUE	PHILADELPHIA
HERNANDEZ, MD, HECTOR N	PHILADELPHIA
HERNANDEZ, MARISOL	STUDENT
HERNANDEZ, MD, ROSE AILEEN M	ALLEGHENY
HERNANDEZ, MD, WILBERT E	LUZERNE
HERNDON, MD, JAMES H	ALLEGHENY
HERNZ, MD, WILLIAM J	CHESTER
HEROLD, MD, SANFORD L	PHILADELPHIA
HEROLD JR, MD, CRESTON C	DAUPHIN
HEROMIN, MD, THOMAS J	NORTHMBRLAND
HERRERA, MD, ANIBAL F	DELAWARE
HERRERO, MD, CARMELO	PHILADELPHIA
HERRERO, MD, REBECCA L	STUDENT
HERRICK, MD, WAYNE C	YORK
HERRING, MD, ALLEN B	PHILADELPHIA
HERRING, MD, GIOLA M	STUDENT
HERRING, MD, WILLIAM	PHILADELPHIA
HERRINGTON, MD, PAMELA J	LYCOMING
HERROLD, MD, LEWIS C	YORK
HERROLD, MD, WARREN C	YORK
HERSCHAFT, MD, RICHARD J	LANCASTER
HERSH, CRAIG P	STUDENT
HERSHENSON, MD, LEE M	ALLEGHENY
HERSHEY, MD, BEVERLY L	PHILADELPHIA
HERSHEY, MD, RICHARD E	ALLEGHENY
HERSHOCK, MD, BRUCE A	WESTMORELAND
HERSHOCK, MD, DIANE M	PHILADELPHIA
HERSPERGER, MD, WEBB S	CUMBERLAND
HERTLE, MD, RICHARD W	PHILADELPHIA
HERTZ, MD, BARRY C	CHESTER
HERTZ, MD, CHARLES S	LEHIGH
HERTZ, GAIL S	STUDENT
HERTZ, MD, JONATHAN	LEHIGH
HERTZOG, MD, JAMES E	ALLEGHENY
HERZBRUN, MD, LEWIS J	ALLEGHENY
HERZEL JR, MD, FRANK B	DAUPHIN
HESKEL, MD, MILTON M	PHILADELPHIA
HESS, MD, EDWARD R	TIOGA
HESS, MD, FLOYD M	NORTHAMPTON
HESS, MD, IVAN W	MONTGOMERY
HESS, MD, J CLAIR	LANCASTER
HESS, MD, JOSEPH B	LANCASTER
HESS, MD, PAUL G	LANCASTER
HESS, DO, RUSSELL C	YORK
HESS, MD, STEVEN G	PHILADELPHIA
HESS, MD, WILLIAM F	MONTOUR
HESSEN, MD, MARGARET T	DELAWARE
HESSINGER, MD, GLEN J	LEHIGH
HESTER, MD, CHRISTOPHER E	DAUPHIN
HESTER, MD, GLORIA E	CHESTER
HESTER, PAUL S	STUDENT
HETKOWSKI, EXEC DIR, ALLAN	LACKAWANNA
HETRICK, MD, WILLIAM D	ALLEGHENY
HEUERMANN, MD, ROBERT P	SCHUYLKILL
HEVEY, MATTHEW P	STUDENT
HEWIE, MD, S P	WASHINGTON
HEWLETT, MD, GUY S	PHILADELPHIA
HEWSON, MD, WILLIAM C	CHESTER
HEY JR, MD, E BERRY	BERKS
HEYAT, MD, PERVIZ	ALLEGHENY
HEYL, MD, LOUIS W	ALLEGHENY
HEYMACH III, MD, GEORGE J	ALLEGHENY
HEYMAN, MD, DAVID C	LYCOMING
HEYMAN, MD, SYDNEY	PHILADELPHIA
HEYWOOD, MD, SUSAN E	CENTRE
HIBBERD, MD, ALAN E	DELAWARE
HICKEY, MD, ANDREW E	YORK
HICKS, MD, EDWARD L	PHILADELPHIA
HIDALGO, MD, HORACIO A	BUCKS
HIDALGO JR, MD, HORACIO A	BUCKS
HIEHLE, MD, J FREDERICK	BERKS
HIGGINS, MD, DAVID E	BLAIR
HIGGINS, DO, KENNETH R	YORK
HIGH, MD, BERTRAND J	BERKS
HIGHAM, MD, CAROL J	ALLEGHENY
HIGHTOWER, MD, MARTIN C	BUCKS
HIJAZI, MD, SAADEDDINE A	LACKAWANNA
HILAL, MD, ELIAS Y	ALLEGHENY
HILBERG, MD, ROBERT W	ALLEGHENY
HILDEBRANDT, MD, CARL A	ALLEGHENY
HILDENBRAND, MD, LISA ANN	DAUPHIN
HILEMAN, MD, JAMES D	ERIE
HILES, MD, DAVID A	ALLEGHENY
HILL, MD, CYNTHIA A	PHILADELPHIA
HILL, MD, DANIEL E	LYCOMING
HILL, MD, E MERTON	LEHIGH
HILL, MD, EDWARD B	CAMBRIA
HILL, MD, JOHN B	ALLEGHENY
HILL, DO, ROBERT J	BLAIR
HILL, MD, THOMAS J	ALLEGHENY
HILLER JR, MD, WALTER W	ALLEGHENY
HILLS, MD, EVERETT C	DELAWARE
HILLS, MD, JAMES R	STUDENT
HILLYER, MD, PETER N	CHESTER
HILTON, MD, ALEXANDER E	ALLEGHENY
HIMELFARB, MD, HILLARD M	FRANKLIN
HIMELSTEIN, MD, BRUCE P	PHILADELPHIA
HIMES, DO, RAND S	MERCER
HIMES JR, MD, RALPH F	BLAIR
HIMMELREICH III, MD, LESTER L	CUMBERLAND
HIMMELSTEIN, MD, EUGENE	DELAWARE
HIMMELSTEIN, MD, FRED R	CHESTER
HINCHBERGER, MD, PAUL A	BUTLER
HINCHLIFFE, MD, JOSEPH G	ALLEGHENY
HINDI, MD, MUSA A	LUZERNE
HINEMAN, MD, MARQUIS W	BEAVER
HINES, MD, RODERICK E	LANCASTER
HINKENS, MD, GEORGE F	ALLEGHENY
HINNEBUSCH, BRIAN F	STUDENT
HINZE, MD, GRETCHEN A	LANCASTER
HIPP, MD, THOMAS J	BUCKS
HIPPLE, MD, RANDALL F	LYCOMING
HIPPS, MD, JOHN G	TIOGA
HIRSCH, MD, BARRY E	ALLEGHENY
HIRSCH, MD, BERNARD	BEAVER
HIRSCH, MD, IRVIN H	PHILADELPHIA
HIRSCH, MD, STANLEY A	ALLEGHENY
HIRSCH, DO, WILLIAM S	BUCKS
HIRSCHOWITZ, WENDY	STUDENT
HIRSH, MD, BERNARD C	PHILADELPHIA
HIRSH, MD, LEONARD F	DELAWARE
HIRSH, MD, S JAY	DELAWARE
HIRTHLER, MD, MAUREEN A	LUZERNE
HISRICH, MD, GLENN D	WASHINGTON
HITCHCOCK, MD, JOHN	ALLEGHENY
HITCHNER, MD, LEWIS C	DELAWARE
HLAVAC, MD, CHERYL A	CHESTER
HLAVAC, JULIEANNE M	STUDENT
HLAVAC, MARK A	STUDENT
HNELESKI JR, MD, IGNATIUS S	CHESTER
HO, MD, CHARLES C L	PHILADELPHIA
HO, MD, CLEMENT T	YORK
HO, LISA Y	STUDENT
HO, MD, SZE-KEY	ERIE
HO, MD, YEE C	ALLEGHENY
HOBART, MD, JOHN H	NORTHAMPTON
HOBBS, MD, JAN D	UNION
HOBBS, MD, JOSEPH H	SCHUYLKILL
HOBBS, MD, ROBERT E	SCHUYLKILL
HOBBS, MD, THOMAS R	DAUPHIN
HOBERMAN, MD, EDWARD	CLINTON
HOBSON, MD, SCOTT R	ALLEGHENY
HOCA, MD, RENATA D	ALLEGHENY
HOCH, MD, BRADLEY R	ADAMS
HOCH, MD, CARL W	ALLEGHENY
HOCH, MD, JOHN J	NORTHAMPTON
HOCH, MD, WILLIS S	BERKS
HOCHBERG, MD, ROBERT D	PHILADELPHIA
HOCHREITER, DO, GEORGE C	ERIE
HOCKENBERRY, MD, SHERRY L	ALLEGHENY
HOCKFIELD, MD, HAL S	MONTGOMERY
HODES, MD, PHILIP J	PHILADELPHIA
HODESS, MD, ARTHUR B	CHESTER
HODGE, MD, ARTHUR J	DAUPHIN
HODGES, MD, JOHN H	PHILADELPHIA
HODGSON, MD, JOHN P	ALLEGHENY
HOELLEIN, MD, DEBORAH E	PHILADELPHIA
HOERNER, MD, GEORGE H	YORK
HOERNER, MD, RALPH W	PHILADELPHIA
HOESSLY, MD, MICHEL C	MONTGOMERY
HOFF, MD, JEANNE	ALLEGHENY
HOFFMAN, MD, ALISA H	PHILADELPHIA
HOFFMAN, ANDREA K	STUDENT
HOFFMAN, MD, ARTHUR D	LEHIGH
HOFFMAN, MD, BRUCE I	PHILADELPHIA
HOFFMAN, MD, CARL J	MONTGOMERY
HOFFMAN, MD, CHAROLETTE	ALLEGHENY
HOFFMAN, MD, CHRISTINE M	BEAVER
HOFFMAN, MD, DAVID A	BERKS
HOFFMAN, DO, DAVID A	MONTOUR
HOFFMAN, MD, DAVID E	NORTHAMPTON
HOFFMAN, MD, DAVID F	CHESTER
HOFFMAN, MD, DAVID J	YORK
HOFFMAN, MD, FRANKLIN D	ALLEGHENY
HOFFMAN, MD, GLENN H	LEBANON
HOFFMAN, MD, HOLLY C	CUMBERLAND
HOFFMAN, MD, HOWARD L	FRANKLIN
HOFFMAN, MD, J DAVID	PHILADELPHIA
HOFFMAN, MD, J LYNN	CUMBERLAND
HOFFMAN, MD, JAMES P	MONTGOMERY
HOFFMAN, MD, JOHN E	NORTHAMPTON
HOFFMAN, MD, JOHN P	PHILADELPHIA
HOFFMAN, DO, MARC E	ALLEGHENY
HOFFMAN, MD, MARK A	PHILADELPHIA
HOFFMAN, MD, NEIL A	BERKS
HOFFMAN, MD, SALEE L	BLAIR
HOFFMAN, MD, WILLIAM J	WESTMORELAND
HOFFMAN, MD, WILLIAM W	LEHIGH
HOFFMAN JR, MD, GEORGE L	PHILADELPHIA
HOFFMAN JR, MD, RICHARD R	LEBANON
HOFFMAN-TERRY, MD, MARGARET L	LEHIGH
HOFFMANN, MD, RON	MONTGOMERY
HOFFMEIER, MD, CHARLES L	PHILADELPHIA
HOFMAN, MD, WALTER I	MONTGOMERY
HOFMANN, MD, DOUGLAS J	YORK
HOFMANN, MD, JAMES W	YORK
HOFMANN, MD, KURT P	MONROE
HOFMANN, MD, MARY T	PHILADELPHIA
HOFMEISTER, MARIETTA A	STUDENT
HOFSTETTER, MD, ALEXANDER M	ALLEGHENY
HOFSTETTER, MD, MARK	ALLEGHENY
HOFSTROM, MD, GLEN T	LYCOMING
HOGAN, MD, RICHARD C	ALLEGHENY
HOGAN, MD, W MICHAEL	MONTGOMERY
HOGAN, MD, WILLIAM R	ALLEGHENY
HOGGE, MD, WILLIAM A	ALLEGHENY
HOH:NG, MD, CHARLES C	ALLEGHENY
HOKE JR, MD, HUGH H	LANCASTER
HOLDER, MD, ARTHUR J	LANCASTER
HOLENCIK, DO, MARK P	DAUPHIN
HOLFELNER, MD, EDWARD D	PHILADELPHIA
HOLL, MD, PAUL F	ALLEGHENY
HOLLA, MD, P SHRIPATHI	LACKAWANNA
HOLLAND, MD, CLARENCE A	LEHIGH
HOLLAND, MD, EDWARD F	YORK
HOLLAND, MD, MARK P	SCHUYLKILL
HOLLAND, MD, SANFORD J	LACKAWANNA
HOLLAND JR, MD, CLARENCE A	LEHIGH
HOLLAND-HULL, MD, NORMAN E	BUCKS
HOLLANDER, MD, ALEXIS C	STUDENT
HOLLANDER, MD, BENTLEY A	PHILADELPHIA
HOLLANDER, MD, GEORGE	PHILADELPHIA
HOLLANDER, MD, IRWIN J	BUCKS
HOLLANDER, MD, JOSEPH L	PHILADELPHIA
HOLLANDS, MD, CELESTE M	PHILADELPHIA
HOLLEN, MD, ROBERT A	CUMBERLAND
HOLLERAN, MD, BERNARD L	LUZERNE
HOLLEY, MD, PAUL S	BEAVER
HOLLIMAN, MD, CECIL J	DAUPHIN
HOLM, MD, ERIC K	BERKS
HOLM, MD, WILLIAM W	MONTGOMERY
HOLMAN, DAWN M	STUDENT
HOLMAN, MD, INGRID A	ALLEGHENY
HOLMBERG, MD, DONALD E	MONTGOMERY
HOLMES, ANDREW S	STUDENT
HOLMES, MD, JOHN J	LACKAWANNA
HOLMS, DO, BARRY C	DELAWARE
HOLSINGER, MD, DAVID F	CAMBRIA
HOLST, MD, HAZEL I	DELAWARE
HOLSTEIN, MD, JAMES J	DELAWARE
HOLT, MD, ALLEN H	MERCER
HOLT, DO, SARAH W	LANCASTER
HOLTZMAN, MD, HENRY B	BUCKS
HOLZINGER, MD, ELMER J	ALLEGHENY
HOM, MD, SOPHIA S	LANCASTER
HOMEIER, BARBARA P	STUDENT
HONEBRINK, MD, ANN L	PHILADELPHIA
HONET, MD, JAMES E	PHILADELPHIA
HONG, MD, KAB S	MONTGOMERY
HONG, MD, KEUMSOON	PHILADELPHIA
HONG, MD, SOO W	LYCOMING
HONG, MD, SUNG H	BEAVER
HONGBARCO, MD, PABLO	ALLEGHENY
HONIG, MD, PAUL J	PHILADELPHIA
HONIGMAN, MD, FREDERIC H	PHILADELPHIA
HONKALA, MD, TIMOTHY K	ALLEGHENY
HOOBLER, MD, RANDALL J	ERIE
HOOD, MD, JOHN M	ERIE
HOOD, MD, KELLY T	PHILADELPHIA
HOOD, THOMAS J	STUDENT
HOON, MD, WILLIAM L	ALLEGHENY
HOOTMAN, MD, BARRY D	BUTLER
HOOVER, MD, ALAN D	ALLEGHENY
HOOVER, MD, CARL H	LANCASTER
HOOVER, MD, DARREN L	ALLEGHENY
HOOVER, MD, DEAN S	YORK
HOOVER, MD, PAUL M	MERCER
HOOVER, MD, PHILIP A	YORK
HOOVER II, MD, BENJAMIN A	YORK
HOOVLER, MD, PHILIP W	BLAIR
HOPE, MD, ALEXANDRA M	VENANGO
HOPKINS, TIM B	STUDENT
HOPP, JENNIFER L	STUDENT
HOPPENFELD, BRAD M	STUDENT
HOPPER, MD, BRUCE D	MONTGOMERY
HORAN, MD, GERALD W	PHILADELPHIA
HORAN, MD, JENNIFER	BERKS
HORAN, MD, KEVIN F	BERKS
HORAN, MD, PARIS B	BRADFORD
HORCHOS, MD, DONALD D	LACKAWANNA
HORMELL, MD, JOHNSON G	BLAIR
HORN, MD, RICHARD H	ALLEGHENY
HORN, MD, THOMAS L	ALLEGHENY
HORN III, MD, FRANK W	YORK
HORNER JR, MD, DANIEL W	MONTGOMERY
HORNSTEIN, MD, LUCY E	CHESTER
HOROWITZ, MD, CAROLYN J	PHILADELPHIA
HOROWITZ, DO, GARY R	PHILADELPHIA
HOROWITZ, MD, GLENN D	PHILADELPHIA
HORROW, MD, JAN C	PHILADELPHIA
HORSLEY, MD, ROSS A	MCKEAN
HORST, MD, ELMER L	BERKS
HORSTMAN, MD, ROSEMARY	PHILADELPHIA
HORT, KURTIS R	STUDENT
HORTH, MD, DANIEL J	WASHINGTON
HORTH, MD, ROBERT M	STUDENT
HORTON, MD, DAVID J	BERKS
HORTON, MD, JOSEPH A	ALLEGHENY
HORVATH, MD, DAVID A	ALLEGHENY
HORVATH, MD, DAVID A	MONTOUR
HORVITZ, DO, STEVEN P	PHILADELPHIA
HORWIN, MD, SAMUEL	CAMBRIA
HORWITZ, MD, BRETT R	MONTGOMERY
HORWITZ, MD, MILTON R	BUCKS
HOSCH, AMY J	STUDENT
HOSPODAR, MD, MARK E	ALLEGHENY
HOSSAIN, MD, AYESHA	WESTMORELAND
HOSSAIN, MD, KASHFIA D	PHILADELPHIA
HOSSAIN, MD, ZAFAR	PHILADELPHIA
HOSSEINI, LEILA D	STUDENT
HOST, MD, WILLIAM R	WYOMING
HOSTEN, MD, EDWARD B	PHILADELPHIA
HOSTETLER, MD, LISA W	DELAWARE
HOSTETTER, MD, ABRAM M	LEBANON
HOTMER, MD, DIANNE D	CHESTER
HOTTENSTEIN, MD, DANIEL W	DAUPHIN
HOTTENSTEIN, MD, JONATHAN E	ALLEGHENY
HOTTENSTEIN, MD, WILLIAM D	LUZERNE
HOU, MD, CHING W	ERIE
HOUCK, MD, HEATHER E	DAUPHIN
HOUGAARD, MD, JOHN P	BUCKS
HOUGH, MD, RODNEY K	CUMBERLAND
HOUIDES, MD, ATHANASIOS C	LEHIGH
HOUSER, MD, JAMES J	VENANGO
HOUSER, MD, LAURA L	ALLEGHENY
HOUSER, MD, SCOTT D	PHILADELPHIA
HOUSER, STEPHEN A	STUDENT
HOUSER, EXEC SEC, JUNE L	CLINTON
HOUSHMAND, MD, CYRUS	CARBON
HOUSMAN, MD, JOHN H	LANCASTER
HOUSTON, MD, DARRYL L	ALLEGHENY
HOUSTON, MD, R ROSS	LAWRENCE
HOUSTON JR, MD, ROBERT R	LAWRENCE
HOVENDEN, MD, ANTHONY L	ALLEGHENY
HOWANITZ, MD, E PAUL	BERKS
HOWANITZ, MD, EMIL P	LUZERNE
HOWARD, CANDACE M	STUDENT
HOWARD, MD, HEDY A	MONTGOMERY
HOWARD, MD, THOMAS K	YORK
HOWE, MD, ELIZABETH W	LANCASTER
HOWE, MD, FRANCIS R C	DAUPHIN
HOWE, MD, J DALE	NORTHAMPTON
HOWELL, MD, JOHN T	BUCKS
HOWELL JR, MD, DAVID D	ERIE
HOWER, MD, ROBERT D	ALLEGHENY
HOWLAND, MD, JAL	ALLEGHENY
HOWLAND, MD, ROBERT H	ALLEGHENY

HOWSE, MD, ROBERT M	LEBANON
HOYER, MD, JOHN R	PHILADELPHIA
HOYLE, MD, J PRESTON	UNION
HOYNE, MD, PATRICIA M	BLAIR
HOYNIAK, MD, ANN L	BERKS
HOYSON, MD, GREGORY M	ALLEGHENY
HOYT, DO, BERNARD S	MERCER
HOYT, DO, DAVID G	MERCER
HOYT, MD, JOHN W	ALLEGHENY
HOYT, MD, RALPH C	BERKS
HOZACK, MD, WILLIAM J	PHILADELPHIA
HRATKO, MD, JOHN R	NORTHAMPTON
HREBINKO JR, MD, RONALD L	ALLEGHENY
HRICISAK, DO, PAULINE M	DAUPHIN
HRINDA, MD, JOHN G	ERIE
HRIVNAK, PATTI L	STUDENT
HRYSHKO, MD, FRANK G	ALLEGHENY
HSIA, MD, RAYMOND W	MONROE
HSIEH, MD, DENNIS S	PHILADELPHIA
HSU, CONNIE W	STUDENT
HSU, EDWIN Y	STUDENT
HSU, GOETHE I	STUDENT
HSU, MD, LEWIS L	PHILADELPHIA
HSU, MD, SHIEN S	WASHINGTON
HSU, MD, WEI T	DELAWARE
HU, MD, KANG-NING	ALLEGHENY
HU, MD, WEI-TZER	SCHUYLKILL
HUANG, MD, CHAO H	PHILADELPHIA
HUANG, MD, CHAU FE	LACKAWANNA
HUBBARD, MD, ANNE M	PHILADELPHIA
HUBBARD, MD, RAYMOND J	BERKS
HUBER, MD, KENNETH C	ALLEGHENY
HUBER, STEPHEN J	STUDENT
HUBSHER, MD, JAY W	DELAWARE
HUDAK, MD, MARY J	YORK
HUDOCK JR, MD, GEORGE E	LUZERNE
HUDOME, MD, SUSAN M	DAUPHIN
HUDSON, MD, HOWARD L	ERIE
HUDSON, MD, MARY P	BERKS
HUDSON JR, MD, HOWARD E	LEHIGH
HUDZICKI, MARIE E	STUDENT
HUDZINSKI, MD, MARTIN	FRANKLIN
HUFF, MD, DENISE	ALLEGHENY
HUFFARD, MD, ROBERT S	CENTRE
HUFFER, MD, DONALD H	YORK
HUFFMAN, MD, PAMELA A	PHILADELPHIA
HUFFNAGLE, MD, HENRY W	LANCASTER
HUGHES, MD, CHRISTOPHER M	ALLEGHENY
HUGHES, MD, DAVID C	INDIANA
HUGHES, MD, DAVID P	LANCASTER
HUGHES, DO, ELIZABETH B	PHILADELPHIA
HUGHES, MD, GEORGE V	ALLEGHENY
HUGHES, MD, HOWARD G	MONTOUR
HUGHES, MD, JAMES M	ALLEGHENY
HUGHES, MD, JANE S	PHILADELPHIA
HUGHES, MD, PATRICK H	ALLEGHENY
HUGHES, MD, PAUL J	LUZERNE
HUGHES, MD, WILLIAM M	WESTMORELAND
HUGHEY, MD, JAMES R	WASHINGTON
HUGO, KRISTINE E	STUDENT
HUGO, MD, MARYANNE	ALLEGHENY
HUHTA, MD, JAMES C	PHILADELPHIA
HULLEY JR, MD, WILLIAM C	ALLEGHENY
HULST, MD, PATRICK J	YORK
HUME, MD, ERIC L	PHILADELPHIA
HUMES, MD, ALEXANDER B	ALLEGHENY
HUMES, MD, REBECCA E	ALLEGHENY
HUMMEL, JAMES P	STUDENT
HUMMER III, MD, CHARLES D	DELAWARE
HUMMER JR, MD, CHARLES D	DELAWARE
HUMPHREY, MD, DAVID M	PHILADELPHIA
HUMPHREYS, MD, EARL A	ALLEGHENY
HUNG, MD, LYNN L Y	ALLEGHENY
HUNN, MD, JONATHAN S	ALLEGHENY
HUNN, MD, RICHARD H	ALLEGHENY
HUNSBERGER, MD, CHARLES L	CAMBRIA
HUNSBERGER, MD, JOSEPH L	MONTGOMERY
HUNSICKER, MD, LLEWELLYN W	MONROE
HUNSICKER, MD, ROBERT C	NORTHAMPTON
HUNT, MD, EUGENE H	BUCKS
HUNT, MD, JOSIAH A	YORK
HUNT, MD, PATRICK J	PHILADELPHIA
HUNT, MD, ROBERT E	BUTLER
HUNT JR, MD, WILLIAM T	PHILADELPHIA
HUNTER, MD, CAROL A	LEHIGH
HUNTER, MD, DORIS M	ALLEGHENY
HUNTER, MD, FRANCES C	PHILADELPHIA
HUNTER, MD, GEORGE R	WESTMORELAND
HUNTER, MD, JAMES M	PHILADELPHIA
HUNTER, MD, JILL V	PHILADELPHIA
HUNTER, MD, JOHN S	BERKS
HUNTER, LINDA L	STUDENT
HUNTER, MD, MARVIN T	BUCKS
HUNTER, MD, ROBERT J	CENTRE
HUNTER, MD, TIMOTHY M	ALLEGHENY
HUNTLEY, MD, ARTHUR C	MONTGOMERY
HUOT, MD, DAVID A	ALLEGHENY
HURH, MD, RYON	ALLEGHENY
HURITE, MD, FRANCIS G	ALLEGHENY
HURLEY, MD, HARRY J	DELAWARE
HURLEY, MD, JEFFREY P	DELAWARE
HURLEY, MD, JOHN N	PHILADELPHIA
HURLOCK, MD, JOAN E	PHILADELPHIA
HUROWITZ, DO, MARC P	PHILADELPHIA
HURSH, MD, DALE K	LANCASTER
HURST, MD, JOHN W	BLAIR
HURST, MD, KENNETH L	LANCASTER
HURTADO, DAVID	STUDENT
HURWITZ, DO, CHARLES	PHILADELPHIA
HURWITZ, MD, DENNIS J	ALLEGHENY
HURWITZ, MD, LARRY E	ALLEGHENY
HUSAIN, MD, SALEEM	PHILADELPHIA
HUSAIN, MD, ZAHID	LUZERNE
HUSAINI, MD, SYED N	ALLEGHENY
HUSHION, MD, WILLIAM F	DELAWARE
HUSSAIN, MD, MUHAMMAD	DAUPHIN
HUSSAINI, MD, SYED R	ALLEGHENY
HUSSEIN, MD, DIAA E	SOMERSET
HUSSON, MD, MICHAEL A	PHILADELPHIA
HUST, MD, FREDERICK S	BUTLER
HUSTED, MD, JAMES W	DELAWARE
HUSTON, MD, CHARLES C	CLARION
HUTCHINGS, MD, DIANA M	BUCKS
HUTCHINSON, MD, THOMAS A	LEHIGH
HUTCHINSON III, DO, HARRY J	CHESTER
HUTCHISON, MD, JAMES C	MONTGOMERY
HUTSON, DO, JODY W	COLUMBIA
HUTT, MD, GORDON H	LANCASTER
HUTTON, MD, JOHN E	YORK
HUTTON, MD, LISA J	MONTGOMERY
HUWE JR, MD, JOSEPH E	ALLEGHENY
HUXSTER, MD, ROBERT H	CHESTER
HWAN, MD, JUNG J	LACKAWANNA
HYATT, MD, FLOYD R	ERIE
HYATT, MD, GLENN A	MONTGOMERY
HYATT, MD, ROBERT W	PHILADELPHIA
HYDE, MD, BRUCE I	ALLEGHENY
HYDOCK, NICOLE A	STUDENT
HYKES, MD, JAMES I	MONTGOMERY
HYLAND, LAWRENCE J	STUDENT
HYLBERT JR, MD, KENNETH W	CENTRE
HYMAN, MD, DAVID S	NORTHAMPTON
HYMAN, MD, HAROLD L	PHILADELPHIA
HYMAN, MD, HERBERT L	LEHIGH
HYNES, MD, ELIZABETH T	DAUPHIN
HYUN, MD, ROBERT	PHILADELPHIA
HYZINSKI, MD, MARTIN B	LACKAWANNA

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IAMS, MD, WILLIAM B	DAUPHIN
IANCU, MD, ALBERT L	ALLEGHENY
IANNACONE, MD, WILLIAM M	PHILADELPHIA
IANNAMORELLI, MD, ANTHONY S	FAYETTE
IANNARONE, MD, LORENZ N	MONTGOMERY
IANNOTTA, MD, PATRICIA N	BUCKS
IANNUZZI, MD, C CHARLES	ALLEGHENY
IBANEZ, MD, MELCHISEDEC	MCKEAN
IBARRA, MD, JOSELUIS	LANCASTER
IBERICO, MD, MARIANO M	MIFFLIN/JUNIATA
ICHTER, MD, JOSEPH T	LUZERNE
ICKLER, MD, JOHN L	MONTGOMERY
IDDENDEN, MD, DAVID A	PHILADELPHIA
IDICULLA, MD, ANNE A	PHILADELPHIA
IDREES, MD, MOHAMMAD	ALLEGHENY
IGE, MD, OLATUJI ABAYOMI	PHILADELPHIA
IGIDBASHIAN, DO, VARTAN N	DELAWARE
IGLESIAS, MD, MANUEL	LANCASTER
IGNACIO JR, MD, GLICERIO V	CAMBRIA
IGNATIUS, MD, PAUL F	WARREN
IGNOCHECK, MD, ANTHONY R	ERIE
IIDA, ERIC S	STUDENT
ILGREN, MD, EDWARD B	MONTGOMERY
ILKHANIPOUR, MD, KAMYAR	ALLEGHENY
ILKHANIPOUR, MD, ZAHRA S	ALLEGHENY
ILLINGWORTH, DO, WILLIAM A	BEDFORD
ILSON, MD, BERNARD E	PHILADELPHIA
IMAIZUMI, MD, SHOTARO	DELAWARE
IMBER, CHRISTOPHER D	STUDENT
IMBER, MD, IRVING	BERKS
IMBRIGLIA JR, MD, JOSEPH E	ALLEGHENY
IMBRIGLIA SR, MD, JOSEPH E	LUZERNE
IMBROGNO, MD, MICHAEL S	LUZERNE
IMPERIALE, MD, SALVATORE M	LUZERNE
IMPINK, MD, ROBERT R	BERKS
INCORVATI, DO, DENNIS L	ALLEGHENY
INCORVATI, DO, ROBERT L	ALLEGHENY
INDORATO, MD, LEROY S	ALLEGHENY
INGAGLIO, MD, PHILIP E	PHILADELPHIA
INGERMAN, MD, MARK J	PHILADELPHIA
INGERSOLL, MD, CHARLES J	PHILADELPHIA
INGLESE, MD, ROBERTO	BEAVER
INNIS, MD, PATRICIA A	BERKS
INOUYE, MD, LISA S	ALLEGHENY
INSCO, RICHARD A	STUDENT
INSERRA, MD, DIANE W	ALLEGHENY
INSLEY JR, MD, MARION C	DAUPHIN
IOCONO, MD, JOSEPH A	DAUPHIN
IORIO, MD, LOUIS J	MCKEAN
IQBAL, MD, NADEEM	BEAVER
IQBAL, MD, SARWAT A	PHILADELPHIA
IQBAL, MD, ZAFAR	ALLEGHENY
IRACKI, MD, DANIEL A	ALLEGHENY
IRANI, MD, MAHAKHURSHID	NORTHAMPTON
IRANI, MD, MAHATAB	NORTHAMPTON
IRANI, MD, ROSHEN N	PHILADELPHIA
IRBY, MD, SUSAN K	ALLEGHENY
IREY JR, MD, PHILIP M	COLUMBIA
IRFAN, MD, MUHAMMAD A	PHILADELPHIA
IRIANA, MD, SARAH M J	DAUPHIN
IRIZARRY, MD, CARMEN P	PHILADELPHIA
IRVIN, MD, FRANCES E C	ALLEGHENY
IRVING, MD, THOMAS H	ALLEGHENY
IRWIN, MD, JOHN T	BUCKS
IRWIN, JOSEPH J	STUDENT
ISAACS, MD, CHARLES T	DAUPHIN
ISAACS, MD, GILBERT H	ALLEGHENY
ISAACSON, MD, HOWARD	PHILADELPHIA
ISAACSON, MD, WAYNE	PHILADELPHIA
ISARD, MD, HAROLD J	PHILADELPHIA
ISARIYAWONGSE, MD, PRAKORB	FAYETTE
ISCKARUS, MD, GEORGE S	MONTOUR
ISCKARUS, MD, MANSOUR S	MONTOUR
ISDANER, MD, NEIL L	PHILADELPHIA
ISENBERG, MD, CHESTER L	HUNTINGDON
ISENBERG, MD, GERALD A	PHILADELPHIA
ISHLER, MD, H RICHARD	CENTRE
ISIDRO, MD, ENRIQUE A	ERIE
ISIDRO, MD, EUGENIO G	LAWRENCE
ISKENDERIAN, MD, KEVORK K	PHILADELPHIA
ISLAM, MD, REZAUL	ALLEGHENY
ISLAMOFF, MD, IGOR I	CAMBRIA
ISMAEL, MD, MOHAMED M	CLARION
ISMAIL, MD, MUHAMMAD S	PHILADELPHIA
ISMAIL-BEIGI, MD, FARHAD	ALLEGHENY
ISRAEL, MD, HAROLD L	PHILADELPHIA
ISRAEL, MD, HOWARD A	LEHIGH
ISRAEL, MD, MICHAEL	ALLEGHENY
ITSKOWITZ, MD, ALAN L	ALLEGHENY
ITSKOWITZ, MD, HARVEY Z	PHILADELPHIA
ITZKOFF, MD, JEROME M	ALLEGHENY
IULIANO, MD, PHILIP J	DAUPHIN
IVANOFF, MD, JOHN G	PHILADELPHIA
IVES, CHARLENE A	STUDENT
IVILL, MD, DENNIS W	DELAWARE
IVINS, MD, JOSEPH L	DELAWARE
IVINS, MD, SAMUEL P	DELAWARE
IVKER, MD, MORRIS	MONTGOMERY
IYER, MD, MANNY S	NORTHAMPTON
IZES, MD, JOSEPH K	MONTGOMERY
IZZO, MD, DOMENIC C	BERKS
IZZO, MD, KENNETH L	PHILADELPHIA

J

JABBOUR, MD, NICOLAS	ALLEGHENY
JABLIN, MD, PETER	FRANKLIN
JABLON, MD, LISA K	PHILADELPHIA
JACKLINE JR, MD, JOSEPH J	ALLEGHENY
JACKSON, MD, FRANK W	DAUPHIN
JACKSON, MD, JAY R	YORK
JACKSON, KELI D	STUDENT
JACKSON, MD, MELVIN L	PHILADELPHIA
JACKSON, MD, PAUL W	DELAWARE
JACKSON, MD, RAYMOND W	BEDFORD
JACKSON, MD, RICHARD D	LANCASTER
JACKSON, MD, TIMOTHY L	BEAVER
JACOB, MD, EMMANUEL E	LUZERNE
JACOB, MD, LEONARD S	PHILADELPHIA
JACOB, MD, W LINDSAY	ALLEGHENY
JACOB JR, MD, THOMAS C	DELAWARE
JACOBELLI, MD, MICHAEL C	BUCKS
JACOBIUS, MD, HENRY F	NORTHAMPTON
JACOBS, MD, CLYDE H	NORTHMBRLAND
JACOBS, MD, DAVID	ALLEGHENY
JACOBS, MD, FRANCIS	CHESTER
JACOBS, MD, GEORGE B	ALLEGHENY
JACOBS, MD, GEORGE J	ALLEGHENY
JACOBS, MD, IRVIN	LUZERNE
JACOBS, MD, JOSEPH A	PHILADELPHIA
JACOBS, MD, JOSEPH M	NORTHAMPTON
JACOBS, MD, KENNETH M	LACKAWANNA
JACOBS, MD, LEWIS M	PHILADELPHIA
JACOBS, MD, MARK	DELAWARE
JACOBS, MD, MARSHALL L	PHILADELPHIA
JACOBS, MD, RICHARD P	ALLEGHENY
JACOBS, MD, RICHARD R	LANCASTER
JACOBS, MD, SAMUEL A	ALLEGHENY
JACOBS, MD, SAMUEL L	PHILADELPHIA
JACOBS, MD, STANLEY R	PHILADELPHIA
JACOBSON, MD, DAVID P	HUNTINGDON
JACOBSON, MD, HORACE H	BRADFORD
JACOBSON, MD, KENNETH L	MONTGOMERY
JACOBSON, MD, MARTIN A	BERKS
JACOBSTEIN, MD, CYNTHIA R	PHILADELPHIA
JACOBSTEIN, MD, JEROME G	PHILADELPHIA
JACOBUS, MD, JUDITH L	BLAIR
JACOBY, MD, RICHARD A	PHILADELPHIA
JACQUES, MD, GEORGE A	ALLEGHENY
JADALI, MD, NASSRIN	PHILADELPHIA
JADIDI, MD, SHIRIN	NORTHAMPTON
JADITZ, DO, STEPHEN G	LACKAWANNA
JAEGER, MD, EDWARD A	DELAWARE
JAEGER, MD, ROBERT M	LEHIGH
JAEGER, MD, SCOTT H	PHILADELPHIA
JAEGER, MD, SCOTT M	ADAMS
JAFAR, MD, MOHAMMAD A	PHILADELPHIA
JAFARI, MD, NERCY	LEHIGH
JAFFARI, MD, MOHAMMED	PHILADELPHIA
JAFFE, MD, JOEL D	BUCKS
JAFFE, MD, JOHN S	LEHIGH
JAFFE, MD, LOUIS	MONTGOMERY
JAFFE, MD, MARVIN E	PHILADELPHIA
JAFFE, MD, STEPHEN C	BUCKS
JAFFEE, DO, LEE	PHILADELPHIA
JAGANNATH, MD, ANAND	DAUPHIN
JAHNLE, MD, RICHARD L	DELAWARE
JAHRE, MD, JEFFREY A	NORTHAMPTON
JAHROMI, MD, HEIDAR K	CHESTER
JAHSHAN, MD, ANTOINE E	PHILADELPHIA
JAIN, MD, ASHOK K	ALLEGHENY
JAIN, MD, SWEETY	NORTHAMPTON
JAKAB, MD, IRENE	ALLEGHENY
JAKABOVICS, MD, EVA	BUCKS
JAKUB, JAMES W	STUDENT
JAKUBEK, MD, DONALD J	WESTMORELAND
JALALI, MD, SHAILEN	PHILADELPHIA
JALOWIEC, DO, MICHAEL A	LACKAWANNA
JAMA, DO, ROBERT H	LACKAWANNA
JAMALI, MD, ANMAR A	DELAWARE
JAMES, CATHERINE A	STUDENT
JAMES, DAVID L	STUDENT
JAMES, DO, EDWARD E	ALLEGHENY
JAMES, MD, EDWARD K	BERKS
JAMES, MD, GEOFFREY M	DAUPHIN
JAMES, MD, JEFFREY R	BERKS
JAMES, MD, RICHARD A	ALLEGHENY
JAMESON, MD, E CARLETON	LANCASTER
JAMIESON, MD, DARA G	PHILADELPHIA
JAMIL, MD, QAZI A	MCKEAN
JAMISON, MD, JAMES P	ALLEGHENY
JAMISON, MD, LISA M	LUZERNE
JAMNBACK, MD, LISA A	ALLEGHENY
JAMSHIDI, MD, JAVAD	BEAVER
JAN, MD, REHANA A	PHILADELPHIA
JAN, MD, RONALD S	PHILADELPHIA
JAN, MD, TAYYABA S	LACKAWANNA
JANA, MD, BARID B	WESTMORELAND
JANA, MD, DILIP K	ERIE
JANAKIRAMAN, MD, VIJAYARA G	BLAIR
JANCO, JENNIFER A	STUDENT
JANECKA, MD, IVO P	ALLEGHENY
JANERICH, MD, ALBERT D	LUZERNE
JANESKY, MD, CINDY	LANCASTER
JANEWAY, MD, TIMOTHY	ALLEGHENY
JANG, MD, JANG-HUEI	LUZERNE
JANG, SUNGYON	STUDENT
JANIAK, DO, DANIEL D	ALLEGHENY
JANICIJEVIC, MD, MILENA	ALLEGHENY
JANICIJEVIC, MD, NENAD	ALLEGHENY
JANNELLI, MD, ANGELA F	BUCKS
JANNELLI, MD, DOROTHY F	ALLEGHENY
JANNETTA, MD, PETER J	ALLEGHENY
JANOFF, HAL B	STUDENT
JANORA, MD, DEANNA M	PHILADELPHIA
JANOSKO, MD, RUDOLPH E M	ALLEGHENY
JANSMA JR, MD, DAVID R	BEAVER
JANSON, MD, RUSSELL R	DAUPHIN
JANSS, MD, ANNA J	PHILADELPHIA
JANTON III, MD, FRANCIS J	DAUPHIN
JAQUISS, MD, G WILLIAM	ALLEGHENY
JARAMILLO, MD, BEVERLY ANN	ALLEGHENY
JARDINE, MD, JILL C	MONTGOMERY
JARDINE, MD, LISA M	STUDENT
JARDINES, MD, LORI A	PHILADELPHIA
JARIWALA, MD, LETICIA Q	ALLEGHENY
JARJOUR, MD, IMAD T	ALLEGHENY
JARMAN, MD, MARTHA L	BUCKS
JARMOLOWSKI, MD, CHESTER R	ALLEGHENY
JAROWENKO, MD, DALEELA G	LANCASTER
JARRETT, MD, FREDRIC	ALLEGHENY
JARVIS, MD, F WAYNE	PHILADELPHIA
JARVIS, JAMES R	STUDENT
JASEK, MD, ANDRZEJ M	MONTGOMERY
JASKO, JOHN J	STUDENT
JASPER, DO, RONALD L	INDIANA
JAURIGUE, MD, VENERANDO G	PHILADELPHIA
JAVAN, MD, MEHDI B	WESTMORELAND
JAVIAN JR, MD, THOMAS A	BUCKS
JAWAD, MD, BASIL S	CHESTER
JAWAD, MD, JAY A	PHILADELPHIA
JAXHEIMER, MD, ERIC C	BERKS
JAY JR, MD, W THOMAS	BERKS
JAYAKUMAR, MD, SUBRAMONIAM	WASHINGTON
JEAN, MICHAEL C	STUDENT
JEFFERIES III, MD, GEORGE E	DAUPHIN
JEFFERS, MD, JOHN B	PHILADELPHIA
JEFFREYS, MD, WILLIAM H	MONTOUR
JEFFRIES, MD, C STEPHEN	ALLEGHENY
JEFFRIES, DO, NANCY E	LANCASTER
JEGASOTHY, MD, BRIAN V	ALLEGHENY
JELEN, MD, JOSEPH A	PHILADELPHIA
JELEN, MD, JOSEPH A	PHILADELPHIA
JELISIJEVIC, MD, ZORICA	PHILADELPHIA
JENCKES III, MD, GEORGE A	BERKS
JENKINS, MD, BARRY L	SCHUYLKILL
JENKINS, MD, BENJAMIN C	BLAIR
JENKINS, MD, DOROTHY S	DELAWARE
JENKINS, MD, JAY L	ERIE
JENKINS, MD, ROSEMARY	DAUPHIN
JENKINS JR, MD, ROBERT J	ALLEGHENY
JENKS, MD, JOHN S	PHILADELPHIA
JENNEY, MD, FLORENCE S	BUTLER
JENNINGS, MD, DAVID T	LYCOMING
JENNINGS, MD, JOHN F	BUCKS
JENNINGS, MD, RICHARD A	ALLEGHENY
JENS, MD, KURTIS D	LANCASTER
JENSEN, MD, GORDON L	MONTOUR
JENSON, MD, CYNTHIA L	ALLEGHENY
JEONG, CHRISTINE M	STUDENT
JEROME-ZAPADKA, MD, KAREN M	BEAVER
JESICK, MD, ANN R	INDIANA
JESICK, GRETCHEN A	STUDENT
JESSAR, MD, RALPH A	PHILADELPHIA
JEW III, MD, EDWARD W	ALLEGHENY
JEW JR, MD, EDWARD W	ALLEGHENY
JEWELL, MD, BRIAN F	ALLEGHENY
JEWELL, MD, MELANIE	PHILADELPHIA
JEWELLS, DO, VALERIE L	PHILADELPHIA
JHO, MD, HAE DONG	ALLEGHENY
JIAS, LISA M	STUDENT
JIMBO, MD, MASAHITO	PHILADELPHIA
JIMENEZ-MEDINA, MD, HERNAN J	MONTGOMERY
JIMERSON, MD, CEDRIC C	BERKS
JIN, MD, BYUNGHAK	FAYETTE
JOBES, MD, DAVID R	PHILADELPHIA
JOCHNOWITZ, MD, MICHAEL J	MONTGOMERY
JOHAN, MD, MORTON	ALLEGHENY
JOHANSON, MD, NORMAN A	PHILADELPHIA

JOHN, MD, BENJAMIN	PHILADELPHIA
JOHN, MD, LAWRENCE R	ALLEGHENY
JOHN, MD, MALIYAKKAL J	COLUMBIA
JOHN, MD, SUNIL C	PHILADELPHIA
JOHN, MD, THOMAS	DELAWARE
JOHN, EXEC DIR, PAUL P	NORTHMBRLAND
JOHNS, MD, MILTON W	LANCASTER
JOHNS IV, MD, WALTER S	ERIE
JOHNSON, MD, ALFRED T	BERKS
JOHNSON, MD, BERNETT L	PHILADELPHIA
JOHNSON, MD, BRETT A	ERIE
JOHNSON, MD, CHARLES F	LEHIGH
JOHNSON, MD, CRAIG H	BERKS
JOHNSON, MD, DANIEL W	BLAIR
JOHNSON, MD, DAVID L	PHILADELPHIA
JOHNSON, MD, DAVID W	ALLEGHENY
JOHNSON, MD, DEAN E	ALLEGHENY
JOHNSON, MD, DENNIS R	YORK
JOHNSON, MD, DON E	PHILADELPHIA
JOHNSON, MD, DOROTHY E	LUZERNE
JOHNSON, MD, DOUGLAS E	LEHIGH
JOHNSON, EDWARD P	STUDENT
JOHNSON, MD, ELTING C	BRADFORD
JOHNSON, MD, FRANKLIN P	ALLEGHENY
JOHNSON, MD, GARY E	ALLEGHENY
JOHNSON, MD, GEORGE M	YORK
JOHNSON, MD, GLEN	BRADFORD
JOHNSON, MD, JAMES K	ALLEGHENY
JOHNSON, MD, JAMES R	ALLEGHENY
JOHNSON, JEANNE D	STUDENT
JOHNSON, MD, JEFFREY H	PHILADELPHIA
JOHNSON, MD, JOAN E	LANCASTER
JOHNSON, MD, JOHN H	BLAIR
JOHNSON, MD, JONAS T	ALLEGHENY
JOHNSON, LAUREL R	STUDENT
JOHNSON, MD, LISA B	CHESTER
JOHNSON, MD, LYNN R	ALLEGHENY
JOHNSON, MD, PETER C	ALLEGHENY
JOHNSON, MD, RICHARD B	ALLEGHENY
JOHNSON, DO, RICHARD E	JEFFERSON
JOHNSON, MD, ROBERT P	LANCASTER
JOHNSON, MD, THOMAS A	PHILADELPHIA
JOHNSON, MD, VAN W	WARREN
JOHNSON, MD, WAINE C	PHILADELPHIA
JOHNSON, MD, WILLIAM T	BERKS
JOHNSON III, MD, S HARRIS	ALLEGHENY
JOHNSON JR, MD, BERTRAM L	LANCASTER
JOHNSON JR, MD, HOWARD J	PHILADELPHIA
JOHNSON-HAMERMAN, MD, LOIS M	PHILADELPHIA
JOHNSONBAUGH, MD, ROGER E	DELAWARE
JOHNSTON, DO, CRAIG T	ERIE
JOHNSTON, MD, FRANK B	PHILADELPHIA
JOHNSTON, MD, JAMES B	VENANGO
JOHNSTON III, MD, JAMES R	CUMBERLAND
JOHNSTON JR, MD, JOHN A	ALLEGHENY
JOHNSTONE, MD, GRAHAM F	ALLEGHENY
JOLLY, MD, RAJ K	ELK/CAMERON
JONES, MD, ANCIL A	DELAWARE
JONES, MD, BRIAN C	ALLEGHENY
JONES, MD, DANIEL C	MONTGOMERY
JONES, MD, DAVID G	LEHIGH
JONES, MD, DAVID J	YORK
JONES, MD, EDWARD R	PHILADELPHIA
JONES, MD, FREDERICK L	HUNTINGDON
JONES, MD, GEORGE J	WASHINGTON
JONES, HORATIO C	STUDENT
JONES, MD, JAMES B	STUDENT
JONES, MD, JAMES E	DAUPHIN
JONES, MD, JEFFRY L	DAUPHIN
JONES, MD, JOSEPH C	ADAMS
JONES, MD, KAREN E	YORK
JONES, MD, KIMBERLY T	PHILADELPHIA
JONES, MD, LARRY W	BLAIR
JONES, MD, MICHAEL W	LYCOMING
JONES, MD, RAYMOND R	CHESTER
JONES, MD, RICHARD E	ADAMS
JONES, MD, ROBERT K	DELAWARE
JONES, MD, ROBYN R	PHILADELPHIA
JONES, MD, STEVEN R	ALLEGHENY
JONES, MD, STUART A	LEHIGH
JONES, MD, THOMAS B	FAYETTE
JONES, TIMOTHY R	STUDENT
JONES, MD, TOM B	MERCER
JONES, DO, WAYNE T	ERIE
JONES, MD, WENDELL E	ALLEGHENY
JONES, DO, WILLIAM H	ERIE
JONES JR, MD, JOHN H	LYCOMING
JONES JR, DO, ROBERT S	BERKS
JONES JR, MD, ROBERT T	ALLEGHENY
JONES-GORDON, MD, SANDRA M	ALLEGHENY
JONOV, MD, CRAIG R	STUDENT
JORDAN, MD, CLAUS G	MONROE
JORDAN, MD, JEROME W	LACKAWANNA
JORDAN, MD, WILLIAM J	LACKAWANNA
JORDAN, MD, WILLIAM P	MONROE
JORDAN III, MD, WALTER E	LACKAWANNA
JORGE, MD, EDUARGO	DAUPHIN
JORGENSEN, MD, BRIAN K	PHILADELPHIA
JORKASKY, MD, DIANE K	PHILADELPHIA
JOSE, MD, CHRISTINE M V	ALLEGHENY
JOSEF, MD, ERNEST M	CUMBERLAND
JOSEPH, MD, ALFRED J	MERCER
JOSEPH, MD, ANDREW H	ALLEGHENY
JOSEPH, MD, ELAINE R	ALLEGHENY
JOSEPH, MD, GEOFFREY	WESTMORELAND
JOSEPH, MD, GEORGE M	NORTHAMPTON
JOSEPH, DO, JEFFREY I	PHILADELPHIA
JOSEPH, MD, KADANKAVIL C	ELK/CAMERON
JOSEPH, MD, RAYMOND J	LUZERNE
JOSHI, MD, HARENDRA V	PHILADELPHIA
JOSHI, MD, KISHOR E	FAYETTE
JOSHI, MD, KUNDABALA S	PHILADELPHIA
JOSHI, MD, MANOHAR J	ALLEGHENY
JOSON, MD, RAYMOND M	PHILADELPHIA
JOURDAIN, MD, LUIS M	BLAIR
JOVANOVICH, MD, DANIEL B	ALLEGHENY
JOY, MD, CHARLES A	ERIE
JOY, MD, CHARLES R	ERIE
JOYCE, MD, ELLEN M	LEHIGH
JOYCE, MD, JUDITH M	ALLEGHENY
JOYCE, MD, MICHAEL F	MONTGOMERY
JOYNER, MD, DAVID M	DAUPHIN
JOZEFCZYK, MD, PATRICIA B	ALLEGHENY
JOZWIAK, MD, MARIOLA R	ALLEGHENY
JUANG, MD, RICHARD C	ERIE
JUBELIRER, MD, ROBERT A	MONTGOMERY
JUDD, MD, JAMES D	MONTGOMERY
JUDGE, MD, JEFFREY A	DAUPHIN
JUDGE, MD, SHEILA	PHILADELPHIA
JUDGE III, MD, JAMES W	CHESTER
JUDSON, MD, JOHN P	DAUPHIN
JUDSON, MD, WILLIAM W	LYCOMING
JUDY, MD, KEVIN D	PHILADELPHIA
JUHASZ, MD, ALEX B	INDIANA
JULES, MD, ARNOLD J	MONTGOMERY
JULIA, MD, RONALD R	NORTHAMPTON
JULIAN, MD, MARYJANE A	SCHUYLKILL
JULIUS, MD, ERNEST L	LUZERNE
JUNCOS, MD, GUILLERMO R	CHESTER
JUNEJA, MD, DAMYANTI	PHILADELPHIA
JUNG, MD, HONG I	LACKAWANNA
JUNG, MD, JAY SOO	LEHIGH
JUNG, MD, JENNIFER L	BUCKS
JUNG, MD, TINLIUNG	MCKEAN
JUNGREIS, MD, CHARLES A	ALLEGHENY
JUNKIN, MD, DAVID M	MONTGOMERY
JUNOD, MD, JOHN B	BUCKS
JURENOVICH, DO, MICHAEL J	MERCER
JURGENS, MD, KENNETH H	ERIE
JURGENSEN, MD, JOHN C	CUMBERLAND
JURIGA, DO, BARBARA M	ALLEGHENY
JURNOVOY, MD, JOEL B	DELAWARE
JUSTICE, WILLIAM H	STUDENT
JUSTIN, MD, PETER A	NORTHMBRLAND
JUSTMAN, MD, JUDITH I	PHILADELPHIA
JUVELIER, MD, BERNARD W	DAUPHIN

K

KAAR, MD, RICHARD C	LYCOMING
KACHEL, MD, THOMAS A	DAUPHIN
KACZMARCZYK, MD, THEODORE R	LACKAWANNA
KACZOR, MD, STANLEY F	BLAIR
KACZOROWSKI, MD, DENISE A	ALLEGHENY
KADIS, MD, MILTON H	LUZERNE
KADIWAR, MD, RAJNIKANT M	SUSQUEHANNA
KAFRISSEN, MD, STEVEN R	LUZERNE
KAGUYUTAN, MD, ALFREDO G	ADAMS
KAGUYUTAN, MD, OFELIA D	ADAMS
KAHLER, MD, GERALD W	VENANGO
KAHLER, MD, ROBERTA A	VENANGO
KAHN, MD, BERNARD L	PHILADELPHIA
KAHN, MD, BERTRAM	MONTGOMERY
KAHN, MD, DONALD L	PHILADELPHIA
KAHN, MD, HYMAN R	PHILADELPHIA
KAHN, MD, MARK B	PHILADELPHIA
KAHN, MD, S BENHAM	PHILADELPHIA
KAHN, MD, SANDRA J	PHILADELPHIA
KAHN, MD, Y RAYMOND	ARMSTRONG
KAIAFAS, COSTAS A	STUDENT
KAIDBEY, MD, KAYS	PHILADELPHIA
KAIN III, MD, THOMAS M	DELAWARE
KAIRYS, MD, LEO R	ALLEGHENY
KAIRYS, MD, MARIE Z	PHILADELPHIA
KAISER, MD, RALPH H	LYCOMING
KAJANI, MD, MEHDI K	PHILADELPHIA
KAJI, AMY H	STUDENT
KAJI, MD, ARJUN V	PHILADELPHIA
KAJI, MD, VIKRAM H	BUCKS
KAKODKAR, MD, VASUNDHARA S	NORTHAMPTON
KALAGAYAN, MD, HECTOR J	ERIE
KALANI, MD, GHASSEM	PHILADELPHIA
KALASH, MD, YASER	ALLEGHENY
KALCHMAN, MD, STEVEN H	BUCKS
KALE, MD, SANJAY D	LEHIGH
KALENAK, MD, ALEXANDER	DAUPHIN
KALES, MD, ANTHONY	DAUPHIN
KALIA, MD, KAMAL K	ALLEGHENY
KALIK, DO, JOSEPH R	MERCER
KALIMAN, MD, EDWARD G	ALLEGHENY
KALIN, MD, NEIL S	PHILADELPHIA
KALISH, MD, ROBERT W	PHILADELPHIA
KALKHOF, MD, THOMAS C	ERIE
KALLA, MD, RICHARD L	ALLEGHENY
KALLOZ, MD, JOHN R	ADAMS
KALMANSON, MD, JACOB D	ALLEGHENY
KALNICKI, MD, SHALOM	ALLEGHENY
KALODNER, DO, DAVID R	DELAWARE
KAMBIN, MD, PARVIZ	PHILADELPHIA
KAMDAR, MD, JAYANT C	PHILADELPHIA
KAMEEN, MD, ANTHONY J	LUZERNE
KAMEN, DO, JONATHAN W	PHILADELPHIA
KAMEN, DO, LEONARD B	PHILADELPHIA
KAMERER, MD, DONALD B	ALLEGHENY
KAMINSKI, MD, ROBERT J	ALLEGHENY
KAMINSKI, MD, THOMAS N	WESTMORELAND
KAMINSKY, MD, JAMES F	ERIE
KAMINSTEIN, MD, DAVID S	CHESTER
KAMSLER, MD, DAVID F	ADAMS
KANAL, MD, EMANUEL	ALLEGHENY
KANDABARAW, MD, ALEXANDER	ALLEGHENY
KANDRA, MD, JOSEPH J	DAUPHIN
KANDULA, MD, RAVINDRA R	NORTHAMPTON
KANE, MD, JAMES A	LACKAWANNA
KANE, MD, JOAN D	LANCASTER
KANE, MD, JOHN J	ALLEGHENY
KANE, MD, JOHN S	MONTGOMERY
KANE, MD, KEVIN M	ALLEGHENY
KANE, MD, MARK J	STUDENT
KANE, MD, RUTH P	ALLEGHENY
KANE, MD, WILLIAM M	DELAWARE
KANEFIELD, DO, MARVIN	PHILADELPHIA
KANEHANN, MD, LISA B	PHILADELPHIA
KANENSON, MD, WILLIAM L	DAUPHIN
KANG, MD, JASBIR S	BEAVER
KANG, MD, JULIE A	BEAVER
KANG, MD, SE-BOO	ARMSTRONG
KANIA, MD, ROBERT J	ALLEGHENY
KANIECKI, MD, ROBERT G	ALLEGHENY
KANIECKI, MD, VIDA S	ALLEGHENY
KANN, BRIAN R	STUDENT
KANN, MD, DAVID	CUMBERLAND
KANN, MD, JULES	ALLEGHENY
KANN, MD, STEVEN E	ALLEGHENY
KANNAN, MD, VAIDEHI	DELAWARE
KANOFF, DO, RICHARD B	PHILADELPHIA
KANOFF, MD, STEVEN J	NORTHAMPTON
KANOUSE, MD, GARY D	COLUMBIA
KANSAGRA, MD, JASMAT N	CAMBRIA
KANSAL, MD, KUSUM R	BLAIR
KANSAL, MD, RAJ G	BLAIR
KANT, MD, NAVAL	UNION
KANT, MD, NILA N	UNION
KANTER, MD, STEVEN L	ALLEGHENY
KANTOR, EDWARD M	STUDENT
KANTOR, DO, JAMES G	PHILADELPHIA
KANTOR, MD, ROBERT J	DAUPHIN
KANTOR, MD, THOMAS V	LEBANON
KANWIT, MD, BERT A	LEHIGH
KAO, MD, CHIEN-KUO	ALLEGHENY
KAO, MD, GARY D	PHILADELPHIA
KAO, MD, WINIFRED W	BERKS
KAO, MD, YI H	CLEARFIELD
KAO, MD, YU SONG	LUZERNE
KAPADIA, MD, DILIP L	DELAWARE
KAPCALA, DO, JAN S	MONROE
KAPLAN, MD, BERNARD S	PHILADELPHIA
KAPLAN, MD, CARL	ALLEGHENY
KAPLAN, DAVID B	STUDENT
KAPLAN, MD, FRANK E	MONTGOMERY
KAPLAN, MD, LAWRENCE M	BERKS
KAPLAN, MD, PAIGE B	PHILADELPHIA
KAPLAN, MD, PETER D	ALLEGHENY
KAPLAN, MD, RICHARD H	PHILADELPHIA
KAPLAN, MD, ROBIN L	BERKS
KAPLAN, MD, ROSALIND D	PHILADELPHIA
KAPLAN, MD, SHELDON J	BERKS
KAPLOW, MD, GWEN H	PHILADELPHIA
KAPOOR, MD, RAJESHWAR D	ALLEGHENY
KAPPAKAS, MD, GEORGE S	ALLEGHENY
KAR, MD, DILIP S	WESTMORELAND
KARA, MD, AOUN B	NORTHAMPTON
KARABELNIK, MD, DON	BERKS
KARAFIN, MD, LESTER	PHILADELPHIA
KARALIS, MD, DEAN G	PHILADELPHIA
KARAMANIAN, MD, AGOP V	ERIE
KARAMCHETI, MD, ANAND	WASHINGTON
KARANJIA, MD, MINOO D	INDIANA
KARASEK, MD, KRISTINA	ALLEGHENY
KARASICK, MD, SHELDON R	PHILADELPHIA
KARAYANNIS, MD, BASIL N	DELAWARE
KARCSH, DO, HENRY J	CHESTER
KARDON, MD, LAURIE A	ALLEGHENY
KARDUCK, MD, JOHN S	CAMBRIA
KAREHA, MD, LOUIS G	LACKAWANNA
KARESS, MD, GINA M	LEHIGH
KARETAS, MD, ALEXANDRA I	PHILADELPHIA
KARIAN, MD, JOHN M	VENANGO
KARIMKHANI, MD, KOBRA	ALLEGHENY
KARKANIAS, MD, CHEROLYN	MONTGOMERY
KARLIN, DO, PAUL S	PHILADELPHIA
KARLSTADT, MD, ROBYN GAIL	PHILADELPHIA
KARNIK, MD, SUBASH S	BUCKS
KARP, MD, ERIC A	LYCOMING
KARP, MD, JOSEPH S	PHILADELPHIA
KARP, MD, LOUIS A	PHILADELPHIA
KARPEN, MD, JAY L	WASHINGTON
KARPENOS, MD, ALEXANDER G	DELAWARE
KARPF, MD, MICHAEL	ALLEGHENY
KARPIN, MD, MAX	DELAWARE
KARPINSKI, MD, HENRY B	ERIE
KARPINSKI JR, MD, STEPHEN J	ALLEGHENY
KARRON, MD, BETTY	LEHIGH
KARSCHNER, MD, JANET K	ALLEGHENY
KARSH, MD, CARL A	ERIE
KART, MD, BARRY H	ALLEGHENY
KARUMBAYA, MD, ROMOLA	LACKAWANNA
KARUNARATNE, MD, ESIRI R	BLAIR
KARVER, MD, SLOAN B	MONROE
KASALES, MD, CLARENCE J	LEBANON
KASARDA, MD, FRANCES E	PHILADELPHIA
KASDAN, MD, RICHARD B	ALLEGHENY
KASDIN, MD, SHARON L	PHILADELPHIA
KASE, MD, GAIL Y	STUDENT
KASE, MD, JAMES J	BERKS
KASE, MD, PAUL F	DAUPHIN
KASE, MD, WILLIAM A	PHILADELPHIA
KASEFF, MD, LEON G	PHILADELPHIA
KASEY, MD, GLORIA R	ALLEGHENY
KASHATUS, MD, WILLIAM C	PHILADELPHIA
KASHURBA, MD, GLENN J	SOMERSET
KASHURBA, MD, MARY T	SOMERSET
KASIRSKY, DO, GILBERT	BUCKS
KASPAR, MD, ALBERT J	NORTHAMPTON
KASPARIAN, MD, HRATCH	PHILADELPHIA
KASPER, MD, KEVIN J	DELAWARE
KASPRENSKI, MD, MATTHEW A	LEHIGH
KASPRENSKI, MD, MATTHEW L	LEHIGH
KASPUTIS, MD, DAVID A	COLUMBIA
KASS, DO, RICHARD W	PHILADELPHIA
KASSYK, MD, MONIKA A	CAMBRIA
KASTELIC, MD, RICHARD M	CAMBRIA
KASTENBAUM, MD, MICHAEL	BERKS
KASTENBERG, MD, DAVID M	PHILADELPHIA
KASTRUP, MD, JOHN J	ERIE
KASUBA, MD, VIDA R	ALLEGHENY
KASUNDRA, MD, PARSHOTTAM N	SCHUYLKILL
KATALAN, MD, MAURICE M	PHILADELPHIA
KATES, MD, JONATHAN L	SOMERSET
KATES, MD, LISA C	STUDENT
KATES, MD, MALCOLM	PHILADELPHIA
KATHIRESAN, SENTHIL M	STUDENT
KATHPAL, MD, GURBACHAN S	ALLEGHENY
KATHURIA, MD, SAJEEV S	ALLEGHENY
KATIN, MD, LAWRENCE I	DELAWARE
KATLIC, MD, MARK R	LUZERNE
KATOWITZ, MD, JAMES A	PHILADELPHIA
KATSAMPES, MD, ERNEST T	DAUPHIN
KATSETOS, MD, CHRISTOS D	PHILADELPHIA
KATTELMAN, DO, MARC	MONTGOMERY
KATZ, MD, ADAM J	ALLEGHENY
KATZ, MD, ALAN J	ALLEGHENY
KATZ, MD, AMIR	PHILADELPHIA
KATZ, MD, DAVID L	ALLEGHENY
KATZ, MD, DAVID M	PHILADELPHIA
KATZ, MD, IAN	CAMBRIA
KATZ, MD, ILENE M	SCHUYLKILL
KATZ, MD, IRWIN L	ALLEGHENY
KATZ, MD, JACOB	PHILADELPHIA
KATZ, MD, JANICE D	PHILADELPHIA
KATZ, MD, JERALD M	WESTMORELAND
KATZ, MD, JOSEPH	LANCASTER
KATZ, MD, JULES	PHILADELPHIA
KATZ, MD, JULIAN	PHILADELPHIA
KATZ, MD, LEO	PHILADELPHIA
KATZ, MD, M RICHARD	PHILADELPHIA
KATZ, MD, MAX	PHILADELPHIA
KATZ, DO, PAUL M	MONTGOMERY
KATZ, MD, RICHARD G	ALLEGHENY
KATZ, MD, RICHARD H	PHILADELPHIA
KATZ, MD, ROBERT E	MONTGOMERY
KATZ, MD, SHEILA M	PHILADELPHIA
KATZ, DO, STEVEN LEE	PHILADELPHIA
KATZ, MD, STUART I	MONTGOMERY
KATZ, MD, WARREN A	PHILADELPHIA
KATZ, MD, WILLIAM	ALLEGHENY
KATZMAN, MD, JEFFREY I	CHESTER
KAUDERER JR, MD, JOHN G	MONROE
KAUFFMAN, MD, CHESTER T	INDIANA
KAUFFMAN, MD, DWIGHT A	LANCASTER
KAUFFMAN, MD, GORDON L	DAUPHIN
KAUFFMAN, MD, WILLIAM S	CUMBERLAND
KAUFMAN, MD, ALAN C	BUCKS
KAUFMAN, MD, BARRE D	LEHIGH
KAUFMAN, MD, CLARK R	LANCASTER
KAUFMAN, MD, JAY H	LEHIGH
KAUFMAN, MD, JODI D	PHILADELPHIA
KAUFMAN, MD, RICHARD E	PHILADELPHIA
KAUFMAN, MD, STEPHEN E	MONTGOMERY
KAUFMANN, MD, ANTHONY M	ALLEGHENY
KAUFMANN, MD, MICHAEL W	LEHIGH
KAUR, MD, MANJEET	LANCASTER
KAUR, MD, PRAKASH	WESTMORELAND
KAUSE, MD, SUZANNE M	ALLEGHENY
KAUSHIK, MD, VED P	ALLEGHENY
KAVCHOK, MD, JOSEPH	LEHIGH
KAVESH, MD, WILLIAM N	PHILADELPHIA
KAVIC, MD, MICHAEL S	ALLEGHENY
KAVIC, MD, THOMAS A	ALLEGHENY
KAVIC, MD, TIMOTHY N	ALLEGHENY
KAVJIAN, MD, EDWARD M	DELAWARE
KAY, MD, GORDON	PHILADELPHIA
KAY, MD, HAROLD R	PHILADELPHIA
KAY, MD, MICHAEL L	PHILADELPHIA
KAYE, MD, ANDREW S	BEAVER
KAYE, MD, DONALD	PHILADELPHIA
KAZAZIAN, CARLA D	STUDENT
KAZEM, MD, ISMAIL	PHILADELPHIA
KAZI, OMAR M	STUDENT
KC, MD, LILLY	LANCASTER
KEAGY, DO, GREGORY S	DAUPHIN
KEAN, MD, DENNIS W	LEHIGH
KEAN, MD, HERBERT	PHILADELPHIA
KEANE, MD, KIMBERLY A	PHILADELPHIA
KEANE, MD, WILLIAM M	PHILADELPHIA
KEARNEY, MD, JAMES D	DAUPHIN
KEARNEY, MD, JOHN M	BERKS
KEARNEY, MD, JOSEPH A	WESTMORELAND
KEARNEY, DO, STARR M	ELK/CAMERON
KEATES, MD, EDWIN U	PHILADELPHIA
KEATING, MD, EDWARD C	LYCOMING
KEATING, MD, PAUL J	DELAWARE
KEATING, MD, WILLIAM J	FRANKLIN
KEBLISH JR, MD, PETER A	LEHIGH
KECK, MD, WILLIAM S	WESTMORELAND
KEDARNATH, MD, SIVA	ALLEGHENY
KEDDIE, MD, ROLAND T	ALLEGHENY
KEECH JR, MD, HAYDEN G	YORK
KEEFER, MD, GEORGE P	PHILADELPHIA
KEELER, MD, LOUIS L	PHILADELPHIA
KEELER, DO, VIRGINIA E M	LUZERNE
KEELEY, MD, MARK S	ALLEGHENY

KEEN, MD, FREDERICK K	ALLEGHENY
KEENAN, MD, GREGORY F	PHILADELPHIA
KEENAN, MD, MARY ANN E	PHILADELPHIA
KEENAN JR, MD, WILLIAM F	LYCOMING
KEENEY, MD, GALEN E	DAUPHIN
KEENEY, MD, GALEN M	HUNTINGDON
KEEPORTS, MD, RICHARD L	YORK
KEFFER, MD, WILLIAM H	BERKS
KEGEL, MD, DANIEL P	LANCASTER
KEGEL, ERICA C	STUDENT
KEGEL, MD, EUGENE E	LANCASTER
KEGEL, MD, JEFFREY G	PHILADELPHIA
KEGEL, MD, MARY F	LANCASTER
KEHM, MD, ROBERT F	YORK
KEHM, MD, VINCENT A	YORK
KEHRLI, MD, HENRY J	LACKAWANNA
KEHRLI, MD, WILLIAM H	LACKAWANNA
KEICHER, MD, LISA F	LEBANON
KEIL, MD, LORETTA W	LEHIGH
KEIM, MD, PETER J	ARMSTRONG
KEISER, MD, E LEE	BERKS
KEISMAN, MD, ROBERT A	DELAWARE
KEITER, MD, JAMES M	LEBANON
KEITH, MD, HELEN R H	NORTHAMPTON
KELBICK, MD, ELAINE H	PHILADELPHIA
KELEMEN, MD, SYLVIA B	DELAWARE
KELHOFFER, MD, ERIC R	PHILADELPHIA
KELLER, MD, FRANK M	ALLEGHENY
KELLER, GREG S	STUDENT
KELLER, MD, JAMES W	LEBANON
KELLER, DO, JON M	LANCASTER
KELLER, MD, LYNWOOD V	BERKS
KELLERMAN, MD, WILMA C	MONTGOMERY
KELLEY, MD, DAVID K	DAUPHIN
KELLEY, MD, KRISTINE	LACKAWANNA
KELLEY, MD, MARK A	PHILADELPHIA
KELLEY, DO, SUZANNE K	DAUPHIN
KELLEY, MD, WILLIAM N	PHILADELPHIA
KELLEY JR, MD, CHARLES F	LEHIGH
KELLIS, MD, DANA S	CAMBRIA
KELLMAN, MD, IAN A	WYOMING
KELLY, MD, ANNE M	PHILADELPHIA
KELLY, MD, BRUCE R	ALLEGHENY
KELLY, MD, EDWARD A	DELAWARE
KELLY, MD, EDWARD G	ALLEGHENY
KELLY, MD, EDWARD J	LACKAWANNA
KELLY, MD, HABIB R	PHILADELPHIA
KELLY, MD, HERBERT T	PHILADELPHIA
KELLY, MD, JAMES J	DELAWARE
KELLY, MD, JEAN A	NORTHAMPTON
KELLY, MD, JOHN A	BRADFORD
KELLY, MD, JOHN J	MONTGOMERY
KELLY, MD, KAREN A	CUMBERLAND
KELLY, MD, KEVIN J	DAUPHIN
KELLY, MD, MARK F	DELAWARE
KELLY, MATTHEW J	STUDENT
KELLY, MD, MAUREEN P	MONTGOMERY
KELLY, MD, PAUL O	DELAWARE
KELLY, MD, ROBERT W	ARMSTRONG
KELLY, MD, THOMAS J	ALLEGHENY
KELLY, MD, WILLIAM E	PHILADELPHIA
KELLY, MD, WILLIAM J	ALLEGHENY
KELLY III, MD, JOHN J	CHESTER
KELLY IV, MD, JOHN D	PHILADELPHIA
KELLY JR, MD, EDWARD A	CHESTER
KELSEY, MD, DAVID M	DELAWARE
KELSO, MD, DON R	MONTGOMERY
KELTON, MD, FRANKLIN C	MONTGOMERY
KELVIN, MD, CARL B	PHILADELPHIA
KEMBERLING, DO, JOHN G	UNION
KEMERER, CHERYL L	STUDENT
KEMMERER, KELLY M	STUDENT
KEMP, MD, ROBERT M	LANCASTER
KEMP, MD, WILLIAM R	ALLEGHENY
KEMP III, MD, DEWITT E	CAMBRIA
KEMPARAJURS, MD, MAVATHUR N	HUNTINGDON
KEMPERS, KEVIN G	STUDENT
KEMPF JR, MD, FRANCIS C	PHILADELPHIA
KEMPNER, MD, BONNIE A	STUDENT
KEMRER, MD, J DONALD	LANCASTER
KENDALL, MD, BENJAMIN	PHILADELPHIA
KENDALL, MD, LEIGH W	LANCASTER
KENEALY, MD, SHAHIRA H	DELAWARE
KENIG, MD, ISADOR J	DAUPHIN
KENKEL, MD, DELIA R	BLAIR
KENKRE, MD, SRICRISHNA B	ALLEGHENY
KENNA, MD, JOSEPH P	LANCASTER
KENNA, MD, MARITA D	ALLEGHENY
KENNARD, MD, JOHN F	CLEARFIELD
KENNEDY, COLLEEN M	STUDENT
KENNEDY, DAVID S	STUDENT
KENNEDY, MD, F BRYAN	ALLEGHENY
KENNEDY, MD, JOHN N	LUZERNE
KENNEDY, DO, JULIA M	BUCKS
KENNEDY, MD, PETER S	YORK
KENNEDY, MD, RICHARD P	MONROE
KENNEDY, MD, SHIRLEY A	WESTMORELAND
KENNEDY, DO, SUSAN M	CHESTER
KENNEDY, MD, THOMAS I	BUCKS
KENNEDY, MD, THOMAS L	MONTOUR
KENNEDY III, MD, ARTHUR R	CARBON
KENNERDELL, MD, EDWARD H	ALLEGHENY
KENNERDELL, MD, JOHN S	ALLEGHENY
KENNEY, MD, DAVID A	WESTMORELAND
KENNEY, MD, LAWRENCE E	MONTGOMERY
KENNEY, MD, NANCY T	CHESTER
KENNING, MD, JAMES A	MONTGOMERY
KENNY, MD, MICHAEL R	COLUMBIA
KENT, MD, GEORGE M	LANCASTER
KENT, MD, RICHARD B	CHESTER
KENT, MD, W DAVID	FRANKLIN
KENTON III, MD, EDGAR J	MONTGOMERY
KENVIN, MD, JOHN E	LEHIGH
KENWORTHY JR, MD, HARRY J	MONTGOMERY
KENZAKOWSKI, LEO F	STUDENT
KEON, MD, THOMAS P	PHILADELPHIA
KEPERLING, DO, MARY O	YORK
KEPP, MD, EDWARD A	VENANGO
KERMAN, MD, KEITH M	PHILADELPHIA
KERMANI, MICHAEL	STUDENT
KERN, MD, FRANK	MONTGOMERY
KERN, MD, FRANKLIN M	PHILADELPHIA
KERNICH, MD, JOSEPH J	JEFFERSON
KERR, MD, KRISS M	YORK
KERR, MD, PAUL B	SUSQUEHANNA
KERR, MD, ROBERT M	LUZERNE
KERR JR, MD, CLARK M	WESTMORELAND
KERR JR, MD, HARRY J	ALLEGHENY
KERRIGAN, MD, JAMES J	MONROE
KERRIGAN, DO, PATRICK J	LUZERNE
KERRY, MD, ROY E	MERCER
KERSHNER, MD, MARILYN S	BERKS
KERSON, MD, LAWRENCE A	MONTGOMERY
KERSTEEN, EXEC DIR, DUANE E	LUZERNE
KERSTEIN, MD, MORRIS D	PHILADELPHIA
KERSTETTER, MD, DAVID L	BEDFORD
KESSEL, MD, LAWRENCE J	PHILADELPHIA
KESSELRING JR, MD, WILLIAM T	MONROE
KESSERU, MD, JULIUS	ALLEGHENY
KESSLER, MD, FRANK J	NORTHAMPTON
KESSLER, MD, GALEN M	ALLEGHENY
KESSLER, MD, LAIBE A	ALLEGHENY
KESSLER, MD, REX K	DELAWARE
KESSLER, MD, WOODROW B	DELAWARE
KESTER, MD, WALTER L	CHESTER
KESWANI, MD, ASHOK K	PHILADELPHIA
KESZELI, MD, ALEXANDER	CHESTER
KETELS, MD, ERK A	BUCKS
KETTERING, MD, DONALD L	WESTMORELAND
KETYER, MD, EDWARD C	ALLEGHENY
KETZAN, MD, TIBOR	ALLEGHENY
KEULER, MD, MARC M	LACKAWANNA
KEVENK, MD, KERIM C	WESTMORELAND
KEVERLINE, JEFFREY P	STUDENT
KEVERLINE, MD, PAUL O	WARREN
KEVISH, MD, BARBARA S	ALLEGHENY
KEVITCH, MD, ROBERT B	LEHIGH
KEYAMANESH, MD, SHAZNEEN J	PHILADELPHIA
KEYES, MD, KATHLEEN J	ALLEGHENY
KEYKHAH, MD, MOHAMMAD M	PHILADELPHIA
KEYSER, MD, GLENN C	DAUPHIN
KEYSER, DO, JEFFREY A	LANCASTER
KHADHIRI, MD, DIANA	DAUPHIN
KHALIFA, MD, NAGIB M	FRANKLIN
KHALIL, MD, KARIM	WESTMORELAND
KHALOUF, DO, FRED K	BLAIR
KHALUPSKY, MD, LARISA	PHILADELPHIA
KHAN, MD, ABID H	ALLEGHENY
KHAN, MD, ANWARULLAH	WESTMORELAND
KHAN, MD, ELIZABETH A	MONTGOMERY
KHAN, MD, MILLY P	CAMBRIA
KHAN, MD, MOHAMMAD A	DELAWARE
KHAN, MD, MOHAMMAD O	DAUPHIN
KHAN, SAMEENA S	STUDENT
KHAN, MD, SAYEED	ALLEGHENY
KHAN, MD, SHAUKAT H	CARBON
KHAN, MD, SULTAN	SCHUYLKILL
KHAN, MD, YASIN N	LEHIGH
KHAN, MD, ZAHID T	BUCKS
KHANDELWAL, MD, MANOJ	MONTGOMERY
KHANNA, MD, SUDHIR K	NORTHMBRLAND
KHAROD, AMIT S	STUDENT
KHATRI, MD, VIJAY P	NORTHAMPTON
KHAW, MD, BERNARD	STUDENT
KHELLA, MD, HANI J	MONTGOMERY
KHELLA, MD, LEWIS	PHILADELPHIA
KHELLA, MD, SAMI L	PHILADELPHIA
KHERA, MD, DINESH C	ERIE
KHETARPAL, MD, SHARAD K	DAUPHIN
KHOLOUSSY, MD, ABDELMOHSEN M	SCHUYLKILL
KHONA, MD, NITHYASHUBA B	PHILADELPHIA
KHOURI, MD, MARGARET	PHILADELPHIA
KHOURY, MD, DENNIS J	PHILADELPHIA
KHOURY, MD, PAUL A	PHILADELPHIA
KHOURY, MD, ZIAD	ALLEGHENY
KHUBCHANDANI, MD, INDRU T	LEHIGH
KHURANA, MD, RAMESH C	ALLEGHENY
KHUSAYEM, MD, MAZEN	CAMBRIA
KHWAJA, MD, RAHILA S	ALLEGHENY
KIBELBEK, MD, MICHAEL J	MONTOUR
KIBELSTIS, MD, JOHN A	LEHIGH
KICHLER, MD, JOEL M	ALLEGHENY
KIEL, MD, STEVEN M	DELAWARE
KIESEL, MD, ROBERT	LEHIGH
KIEWE, MD, RANDY P	STUDENT
KIGHTLINGER, DO, JAMES	CLEARFIELD
KIHARA, MD, TODD K	MONTOUR
KIHM, MD, RONALD H	BLAIR
KIKKAWA, MD, KAZUTOSHI	BRADFORD
KILCHEVSKY, MD, EITAN S	BERKS
KILFOIL, MD, MARY M	DELAWARE
KILLIAN, MD, DOROTHEA M	MONTGOMERY
KILLIAN, MD, PAUL J	ALLEGHENY
KILLIAN III, MD, CALEB L	BERKS
KILMORE JR, MD, VANCE E	DAUPHIN
KILPATRICK, MD, GERTRUDE E	BEAVER
KILPATRICK, MD, WILLIAM F	WASHINGTON
KILPATRICK, EXEC DIR, WILLIAM H	NORTHAMPTON
KILPELA, MD, DONALD A	ALLEGHENY
KIM, ANDREW S	STUDENT
KIM, ANJE	STUDENT
KIM, CHI Y	STUDENT
KIM, CHONG M	STUDENT
KIM, MD, CHRISTOPHER Y	ALLEGHENY
KIM, MD, CHUNG H	LEHIGH
KIM, MD, CHUNG S	BERKS
KIM, DANNY C	STUDENT
KIM, MD, DAVID Y	STUDENT
KIM, MD, DONG H	FAYETTE
KIM, MD, DONG H	WESTMORELAND
KIM, MD, DOO T	NORTHAMPTON
KIM, MD, EDWARD	PHILADELPHIA
KIM, MD, ERICH	YORK
KIM, MD, EUGENE Y	ALLEGHENY
KIM, MD, HACK J	LANCASTER
KIM, MD, HAEWON C	PHILADELPHIA
KIM, MD, HI S	MONTGOMERY
KIM, MD, HWAN Y	CAMBRIA
KIM, MD, HYOUNG D	ALLEGHENY
KIM, MD, HYUNG-BAE	LUZERNE
KIM, MD, IH C	NORTHAMPTON
KIM, MD, IL G	LYCOMING
KIM, MD, IN-SOON	BUCKS
KIM, MD, INKYO	SCHUYLKILL
KIM, MD, JAE-CHIL	ALLEGHENY
KIM, DO, JAMES B	MONROE
KIM, MD, JE H	LAWRENCE
KIM, MD, JIN I	LEHIGH
KIM, MD, JIN R	MONTGOMERY
KIM, MD, JUNG S	PHILADELPHIA
KIM, MD, KWAN E	PHILADELPHIA
KIM, DO, MI YE	YORK
KIM, MINA H	STUDENT
KIM, MD, MYOUNG S	FAYETTE
KIM, MD, PAUL S	CHESTER
KIM, MD, SANG M	JEFFERSON
KIM, MD, SCOTT S	ALLEGHENY
KIM, MD, SEA H	MONTGOMERY
KIM, MD, SUN C	SCHUYLKILL
KIM, MD, SUNG Y	ALLEGHENY
KIM, MD, UH G	BEAVER
KIM, MD, WAN J	LAWRENCE
KIM, MD, WHA S	FAYETTE
KIM, MD, WHA SUN	ALLEGHENY
KIM, MD, YANG K	BUTLER
KIM, MD, YONG DEOK	ALLEGHENY
KIM, MD, YONG IL	WESTMORELAND
KIM, MD, YOON C	ALLEGHENY
KIM, MD, YOUNG B	CHESTER
KIM, MD, YOUNG W	BUCKS
KIM, MD, YUNG S	BUCKS
KIMBALL, MD, C EVE J	BERKS
KIMBALL, MD, HARRY R	PHILADELPHIA
KIMBALL JR, MD, DANIEL B	BERKS
KIMBER JR, MD, ROGER G	LEBANON
KIMBIRIS, MD, GEORGE	PHILADELPHIA
KIMBLE, DO, GREGORY A	BLAIR
KIMCHI, ERIC T	STUDENT
KIMELHEIM, DO, ROBERT A	MONTGOMERY
KIMLESS-GARBER, MD, DEBRA B	DELAWARE
KIMMEL, MD, CRAIG A	BERKS
KIMMEL, MD, DEBORAH N	LEHIGH
KIMMEL, MD, HENRY A	DELAWARE
KIMMEL, MD, MURRAY H	PHILADELPHIA
KINDER, MD, ROY R	DELAWARE
KING, MD, ANDREW J	CAMBRIA
KING, MD, ARTHUR B	BRADFORD
KING, MD, BARBARA L	ALLEGHENY
KING, DO, BERNARD F	PHILADELPHIA
KING, KEVIN J	STUDENT
KING, MD, LEO M	ALLEGHENY
KING, MD, LOIS I	PHILADELPHIA
KING, MD, LORRAINE C	PHILADELPHIA
KING, MD, PHILLIP E	CAMBRIA
KING, MD, WEIR L	BERKS
KING JR, MD, WILLIAM F	PHILADELPHIA
KINGHORN, MD, MILDRED A	ALLEGHENY
KINGSBURY, MD, ROBERT C	MONTGOMERY
KINKEAD, MD, KEVIN P	LUZERNE
KINLAW, MD, W BERNARD	MONTGOMERY
KINNEY, MD, MARY S	WESTMORELAND
KINNIRY, PAUL A	STUDENT
KINOSIAN, MD, MARY J	JEFFERSON
KINTZEL, MD, JAMES E	LEHIGH
KINTZER JR, MD, JOHN S	NORTHAMPTON
KINTZI, MD, HARRY E	LANCASTER
KIOK, MD, MAXIMO C	FAYETTE
KIPP, MD, JAMES E	LANCASTER
KIRBY, MD, CLAUDE W	CAMBRIA
KIRBY, MD, JAMES E	YORK
KIRBY JR, MD, WILLIAM H	YORK
KIRCHHOFER, MD, LEWIS H	DELAWARE
KIRCHNER, MD, G GARY	LANCASTER
KIRCHNER, DO, JEFFREY T	LANCASTER
KIRINDONGO, MD, ANTHONY	ALLEGHENY
KIRK, MD, DANIEL L	NORTHMBRLAND
KIRKER JR, MD, WALTER R	DAUPHIN
KIRKLAND, MD, MATT L	PHILADELPHIA
KIRKPATRICK, MD, DANIEL W	MONTGOMERY
KIRKPATRICK, MD, SAMUEL A	YORK
KIRKPATRICK, MD, WILLIAM H	PHILADELPHIA
KIRKPATRICK JR, MD, DAVID D	CRAWFORD
KIRSCH, MD, PAUL B	MCKEAN
KIRSCHBAUM, DO, MICHAEL J	PHILADELPHIA
KIRSHBAUM, MD, BERNARD A	PHILADELPHIA
KIRSHEN, MD, MICHELLE R	ALLEGHENY
KIRTLAND III, MD, HOWARD H	VENANGO
KISH, MD, GEORGE F	ERIE
KISH, DO, JOHN M	LUZERNE
KISH, LAURENCE M	STUDENT
KISH, MD, ROBERT S	CENTRE
KISKADDON, MD, JAMES C	FRANKLIN
KISLAN, MD, KIRA	WASHINGTON
KISLOFF, MD, BARRY	ALLEGHENY
KISNER, MD, ROBERT G	ALLEGHENY
KISSELL, MD, DEWITT C	ALLEGHENY
KISSICK, MD, WILLIAM L	PHILADELPHIA
KISSOONDIAL, MD, PREM B	ERIE
KISTLER, MD, DAVID W	LUZERNE
KISTLER, MD, KERMIT K	LEHIGH
KISTLER, MD, MEG S	MONTOUR
KISTLER, MD, PRISCILLA J	MONTGOMERY
KISTLER, MD, WARREN D	FRANKLIN
KISTLER, MD, WILLIAM S	MONTGOMERY
KITAY, MD, STEVEN E	ALLEGHENY
KITCHEN II, MD, JAMES G	MONROE
KITCHEN III, MD, JAMES G	DELAWARE
KITEI, MD, MILTON N	PHILADELPHIA
KITEI, MD, ROBERT A	PHILADELPHIA
KITSKO, DO, DENNIS	WASHINGTON
KITSKO, MD, WILLIAM T	CAMBRIA
KITTLEBERGER, MD, WILLIAM C	BUCKS
KITZMILLER, MD, JOHN K	DAUPHIN
KIVITZ, MD, ALAN J	BLAIR
KLAG, DO, JOSEPH V	BEAVER
KLASKIN, DO, BRUCE D	YORK
KLASKO, MD, STEPHEN K	LEHIGH
KLASS, MD, DANIEL J	PHILADELPHIA
KLATCHKO, MD, BARBARA A	MONTGOMERY
KLATMAN, MD, SAMUEL J	ALLEGHENY
KLATT, BRIAN A	STUDENT
KLAUS, MD, THOMAS C	ERIE
KLAVAN, MD, MARSHALL	DELAWARE
KLAY, MD, JOHN W	ALLEGHENY
KLEAVELAND, MD, JOSEPH P	LEHIGH
KLECKNER, MD, FRANCIS S	LEHIGH
KLEEMAN, MD, AUDREY K	BUCKS
KLEES, MD, ATHANASIUS	LEHIGH
KLEES, DO, DAVID A	ERIE
KLEES, MD, JULIA E	PHILADELPHIA
KLEIMAN, MD, ROBERT B	PHILADELPHIA
KLEIN, MD, ALAN H	ALLEGHENY
KLEIN, MD, ALBERT	ALLEGHENY
KLEIN, MD, DOROTHY E	PHILADELPHIA
KLEIN, MD, FRED S	WASHINGTON
KLEIN, MD, IRVING	ARMSTRONG
KLEIN, MD, JOSEPH F	CHESTER
KLEIN, MD, JOSEPH M	LUZERNE
KLEIN, MD, LAWRENCE	MONROE
KLEIN, MD, MICHAEL A	YORK
KLEIN, MD, MICHAEL E	DAUPHIN
KLEIN, DO, MILTON J	ALLEGHENY
KLEIN, MD, MORDECAI N	ALLEGHENY
KLEIN, MD, RAYMOND A	DELAWARE
KLEIN, MD, RICHARD M	ALLEGHENY
KLEIN, MD, SHELDON	PHILADELPHIA
KLEIN, MD, THOMAS E	DELAWARE
KLEIN JR, MD, WILLIAM J	BERKS
KLEINER, MD, ANTON J	BERKS
KLEINER, MD, HENRY T	PHILADELPHIA
KLEINER, MD, ROBERT C	PHILADELPHIA
KLEINERT, MD, RICHARD W	CLEARFIELD
KLEINMAN, DO, JAY M	NORTHAMPTON
KLEINSCHMIDT, MD, ROBERT F	ALLEGHENY
KLEM, MD, ALBERT J	LUZERNE
KLEMENS, MD, ROBERT F	CAMBRIA
KLEPPINGER, MD, RICHARD K	BERKS
KLETTER, MD, JAN C	SUSQUEHANNA
KLIEGER, MD, HERMAN L	WESTMORELAND
KLIEGER, LOUIS L	STUDENT
KLIGERMAN, MD, MORTON M	PHILADELPHIA
KLIGMAN, MD, ALBERT M	PHILADELPHIA
KLIMES, MD, RONALD L	YORK
KLINE, DO, GLENN A	LANCASTER
KLINE, MD, IRWIN K	DELAWARE
KLINE, MD, JACK A	YORK
KLINE, MD, MATTHEW T	PHILADELPHIA
KLINE, MD, MICHAEL S	BLAIR
KLINE, MD, ROBERT M	LEBANON
KLINE, MD, ROBERT W	ALLEGHENY
KLINE, MD, TILDE S	DELAWARE
KLINEFELTER, MD, HYLDA C	DELAWARE
KLINEK, MD, MICHELLE M	PHILADELPHIA
KLINGENSMITH, MD, MARK R	WESTMORELAND
KLINGENSMITH, MD, WALTER C	PHILADELPHIA
KLINGER, MD, HARRY M	MONTOUR
KLINGHOFFER, MD, JUNE F	PHILADELPHIA
KLINGHOFFER, MD, LEONARD	PHILADELPHIA
KLINMAN, MD, STEVEN W	PHILADELPHIA
KLINMAN, MD, WILLIAM	PHILADELPHIA
KLINZING, MD, GERARD F	DELAWARE
KLIONSKY, MD, BERNARD L	ALLEGHENY
KLOEHN, MD, GREGORY C	ALLEGHENY
KLOIN, MD, JAY E	LEHIGH
KLOMBERS, MD, LEE A	BERKS
KLOS, JULIAN W	STUDENT
KLOSE, MD, PAUL L	SOMERSET
KLOTZ, MD, DONALD J	LEHIGH
KLUFAS, MD, ALEXANDER J	CHESTER
KLUFT, MD, RICHARD P	PHILADELPHIA
KLUG, MD, GERALD D	ALLEGHENY
KMETZO, MD, JAMES J	BUCKS
KNAPP, MD, MICHAEL A	BUCKS
KNAPP, MD, ROBERT C	BEAVER
KNAPP, DO, STEPHANIE A	BUCKS

KNAPPENBERGER, MD, GEORGE F	ALLEGHENY
KNAPPER, MD, ELIZABETH J	LEHIGH
KNAUB, MD, MARILYN B	LANCASTER
KNAUB, MARK A	STUDENT
KNAUSS-BROWN, CHRISTINA C	STUDENT
KNEBEL, DO, RICHARD A	MONTOUR
KNECHT, MD, CHARLES L	LEHIGH
KNEIFATI, MD, AHMED	NORTHMBRLAND
KNEPLEY, MD, DAVID W	COLUMBIA
KNEPP, MD, ELIZABETH E	ALLEGHENY
KNEPPER, MD, JOSEPH A	LANCASTER
KNEPPER, MD, LAURIE E	ALLEGHENY
KNERR, MD, RICHARD A	CENTRE
KNERR JR, MD, EDGAR D	LANCASTER
KNIAZER, MD, BARRY	BERKS
KNIGHT, ADINA K	STUDENT
KNIGHT, MD, BARBARA S	PHILADELPHIA
KNIGHT JR, MD, EMERSON L	DAUPHIN
KNOCH, MD, H ROEBLING	YORK
KNOLL, MD, GEORGE M	NORTHAMPTON
KNORR, ERIC J	STUDENT
KNOUSE, MD, ALBERT B	BUCKS
KNOUSE, MD, MARK C	LEHIGH
KNOWLES, MD, WILLARD E	DELAWARE
KNOX JR, MD, JAMES D	CHESTER
KNOX-LEE, DO, MARGARET M	LANCASTER
KNUPP, MD, DONNA L	ALLEGHENY
KNUPP, MD, MELVIN L	DAUPHIN
KO, MD, CHAN S	SCHUYLKILL
KO, MD, EUGENE C H	LANCASTER
KO, MD, MIN-HSIUNG	PHILADELPHIA
KO, MD, YIH-SHYONG	CARBON
KO, MD, YIH-SONG	MERCER
KOBAK, GREGORY E	STUDENT
KOBALY, MD, DAVID J	ALLEGHENY
KOBLENZER, MD, FRANCES E S	PHILADELPHIA
KOCAN, MD, RICHARD S	ERIE
KOCH, MD, ANDREW W	LANCASTER
KOCH, MD, JOSEPH C	NORTHAMPTON
KOCH, MD, L VON	LACKAWANNA
KOCH, MD, PAMELA J	LANCASTER
KOCH, MD, THOMAS J	LEHIGH
KOCHU, MD, STEVE	BERKS
KODROFF, MD, KURT S	PHILADELPHIA
KODSI, MD, MAGDI S	PHILADELPHIA
KODUMAL, MD, LUIS E	DELAWARE
KOEHLER, MD, WILLIAM P	BUCKS
KOELLER, MD, ROYAL R	CAMBRIA
KOELSCH, MD, ROBERT R	BUCKS
KOENIG, MD, JOHANN A	LUZERNE
KOENIG, MD, MARK A	ALLEGHENY
KOENIG, MD, THEODORE R	CLARION
KOEPSELL, MD, DON G	CHESTER
KOERBER JR, MD, WALTER A	DAUPHIN
KOFELDT, LINDA M	STUDENT
KOFSKY, MD, PHILLIP M	MONTGOMERY
KOFSKY, MD, STANTON	PHILADELPHIA
KOHAN, DO, DAVID A	LEHIGH
KOHL, MD, DAVID H	ARMSTRONG
KOHL, MD, E JAMES	PHILADELPHIA
KOHL, MD, STEPHEN D	BERKS
KOHLER, MD, LISA J	ALLEGHENY
KOHLER, EXEC SEC, MICHAEL P	CAMBRIA
KOHLHAS, MD, JACOB J	MONTGOMERY
KOHLI, MD, HARJEET P	NORTHAMPTON
KOHN, MD, MARK I	PHILADELPHIA
KOHRT, MD, ALAN E	WAYNE/PIKE
KOHUT, DO, PAUL A	ERIE
KOHUTIAK, MD, VSEVOLOD	DELAWARE
KOIMATTUR, MD, ARWIND	ALLEGHENY
KOIWAI, MD, EICHI K	PHILADELPHIA
KOKALES, MD, JOHN G	ALLEGHENY
KOLANSKY, MD, HAROLD	PHILADELPHIA
KOLATIS, MARY ELLEN	STUDENT
KOLB, MD, AARON J	LYCOMING
KOLBER, MD, LAUREN R	BUCKS
KOLLAS, MD, CHAD D	MONTOUR
KOLLER, MD, HAROLD P	MONTGOMERY
KOLLMAN, MD, KEVIN J	BLAIR
KOLMEN, MD, BARBARA K	ALLEGHENY
KOLONICH, MD, KIMBERLY A	MIFFLIN/JUNIATA
KOLTER, MD, JAMES S	CHESTER
KOLTER JR, MD, JOSEPH P	ALLEGHENY
KOLTES, MD, JOHN A	PHILADELPHIA
KOLUCKI, MD, FRANK R	LACKAWANNA
KOMAN, MD, CHRISTOPHER G	STUDENT
KOMEN, MD, SUPOTE S	WASHINGTON
KON, DO, LISA A	MONTOUR
KONCELIK, DO, JOHN J	ALLEGHENY
KONCHANIN, MD, LYNN M	BUCKS
KONCHAR, MD, WILLIAM C	YORK
KONDASH, DO, DENNIS J	LACKAWANNA
KONDASH, DO, MICHAEL L	LACKAWANNA
KONDAVEETI, MD, KOTAYYA	ALLEGHENY
KONDRATOWSKI, MD, RICHARD Z	PHILADELPHIA
KONDROT, MD, EDWARD C	ALLEGHENY
KONECKE, MD, M LOUIS	LUZERNE
KONHAUS, MD, CAROL H	DAUPHIN
KONKEL, MD, KAREN E	YORK
KONTAK, MD, JEFFERY R	ALLEGHENY
KONTRA, MD, JOSEPH M	LANCASTER
KONTRICK, AMY V	STUDENT
KOO, MD, KIM ENG	PHILADELPHIA
KOO, MD, WOOK H	LUZERNE
KOOLPE, MD, HARVEY A	PHILADELPHIA
KOOLPE, MD, LOUIS	PHILADELPHIA
KOOPMAN, MD, PETER J	ALLEGHENY
KOOPMAN, MD, RICHELLE D	ALLEGHENY
KOOROS, MD, KIAN S	ALLEGHENY
KOPEN, MD, DAN F	LUZERNE
KOPENHAVER, MD, DONALD B	LEHIGH
KOPNICKY, AIMEE J	STUDENT
KOPPEL, ADAM M	STUDENT
KOPPELMAN, GAYLE M	STUDENT
KOPRESKI, MD, MARY M C	DAUPHIN
KOPYT, DO, NELSON P	LEHIGH
KORBONITS, MD, CHARLES W	CHESTER
KORENTZWITT, MD, EDITH	PHILADELPHIA
KOREVAAR, MD, WILHELMINA C	MONTGOMERY
KOREY, MD, JOSEPH J	PHILADELPHIA
KOREY JR, MD, JOSEPH J	BERKS
KORHAMMER, MD, ALAN F	NORTHAMPTON
KORINCHAK, MD, JEROME L	MIFFLIN/JUNIATA
KORMAN, MD, H SHIRLEY	ALLEGHENY
KORNBLITH, MD, PAUL L	ALLEGHENY
KORNELUK-REILLY, MD, THERESA	PHILADELPHIA
KORNFIELD, MD, NORMAN B	LANCASTER
KORNIENKO, MD, WALTER A	DELAWARE
KORNSGOLD, LAURA M	STUDENT
KORT, MD, JOSEPH F	NORTHMBRLAND
KOSA, MD, NAMIR B	DELAWARE
KOSCO, MD, GEORGE M	JEFFERSON
KOSCO III, DO, GEORGE M	DAUPHIN
KOSENKO, MD, ALEXANDER	ERIE
KOSHAR, MD, MARK I	NORTHAMPTON
KOSHINSKI, DO, RITA S	PHILADELPHIA
KOSHY, AJAY	STUDENT
KOSIK, DO, JAMES J	LACKAWANNA
KOSLOW, ANDREW H	STUDENT
KOSSOFF, MD, DAVID W	ALLEGHENY
KOSSOL, MD, JANET M	ALLEGHENY
KOST, MD, KENNETH R	ARMSTRONG
KOSTER, MD, LEE H	WESTMORELAND
KOSTYAL, MD, JOHN L	ALLEGHENY
KOTAKIS, MD, JOHN	PHILADELPHIA
KOTAPKA, MD, MARK J	PHILADELPHIA
KOTCHICK, MD, E DONALD	LACKAWANNA
KOTLARCZYK, MD, JAROSLAW J	PHILADELPHIA
KOTLER, MD, BARRY M	PHILADELPHIA
KOTLER, MD, FREDERICK B	ALLEGHENY
KOTLOFF, MD, LEON	PHILADELPHIA
KOTSENAS, MD, AMY L	PHILADELPHIA
KOTT, BETSY L	STUDENT
KOTTAPALLY, MD, SRINIVAS M	ALLEGHENY
KOTTNER JR, MD, WILLIAM W	WASHINGTON
KOTWAL, MD, NEVILLE H	PHILADELPHIA
KOTWAL, MD, NIRMAL D	ALLEGHENY
KOTYO, MD, JOHN A	DELAWARE
KOUGH, MD, ROBERT H	MONTOUR
KOUKAL, DO, JONATHAN L	LAWRENCE
KOUKAL, MD, LUDWIG R	LAWRENCE
KOUSEN, MD, MORTON	YORK
KOUTCHER, MD, MARTIN E	PHILADELPHIA
KOUVELIOTES, PETER J	STUDENT
KOVACS, DO, JAMES E	LUZERNE
KOVALOVICH, MD, KELLEN K	PHILADELPHIA
KOVALSKI, MD, RAYMOND	CHESTER
KOVALSKY, MD, DON A	PHILADELPHIA
KOVALSKY, MD, EVAN S	MONTGOMERY
KOVALSKY, MD, KENNETH	BERKS
KOVAR, MD, CHARLES E	NORTHAMPTON
KOVATCH, MD, ANTHONY L	ALLEGHENY
KOVEL, MD, ARTHUR J	ALLEGHENY
KOVEN, MD, NORMAN L	PHILADELPHIA
KOWALSKI, CHRISTOPHER M	STUDENT
KOWALSKI, MD, THOMAS E	DELAWARE
KOWALYK, MD, STEPHAN	WESTMORELAND
KOWALYSHYN, MD, MICHAEL J	BUCKS
KOWTONIUK, DO, WALTER V	CAMBRIA
KOZART, MD, DAVID M	PHILADELPHIA
KOZERA, MD, RICHARD J	PHILADELPHIA
KOZIN, MD, WILLIAM	DELAWARE
KOZINN, MD, WESLEY P	NORTHAMPTON
KOZLOWSKI, DO, MARYANN	ERIE
KOZMINSKY, MD, MARK E	CENTRE
KOZUB, MD, ROBERT E	PHILADELPHIA
KRABLIN, MD, RONALD	ADAMS
KRACKOW, MD, JOEL A	DELAWARE
KRAEBBER, MD, MARKUS J	STUDENT
KRAFCHIN, MD, IRA C	LACKAWANNA
KRAFT, WALTER K	STUDENT
KRAFT JR, MD, ALBERT J	MONTGOMERY
KRAFTOWITZ, MD, ROBERT E	ALLEGHENY
KRAH, EXEC DIR, JOHN G	ALLEGHENY
KRAIN, MD, RAYMOND	DELAWARE
KRAJESKI, MD, R DREW	BUCKS
KRAK, MD, MICHAEL	ALLEGHENY
KRAKOVITZ, MD, JAY A	PHILADELPHIA
KRALJEVIC, MD, JUAN E	BERKS
KRALL, MD, J THOMAS	DELAWARE
KRALSTEIN, MD, JEFFREY R	LEHIGH
KRAM, MD, JOHN E	ALLEGHENY
KRAMER, MD, ARNOLD	LUZERNE
KRAMER, MD, DAVID J	PHILADELPHIA
KRAMER, MD, FREDERICK L	PHILADELPHIA
KRAMER, DO, JOEL R	MONTGOMERY
KRAMER, MD, KENNETH	NORTHAMPTON
KRAMER, MD, MARK S	PHILADELPHIA
KRAMER, MD, MARK S	PHILADELPHIA
KRAMER, RACHEL L	STUDENT
KRAMER, MD, RANDALL K	BERKS
KRAMER, MD, ROBERT E	CAMBRIA
KRAMER, RYAN M	STUDENT
KRAMER, MD, SANDRA S	PHILADELPHIA
KRAMER, MD, SELMA	PHILADELPHIA
KRAMER, MD, WILLIAM A	FRANKLIN
KRANE, MD, MARVIN A	PHILADELPHIA
KRANIK, MD, ANDREW D	ALLEGHENY
KRANTZ, MD, KATHRYN E	PHILADELPHIA
KRANTZ, MD, WALTER J	MONTGOMERY
KRANTZLER, MD, JOSEPH D	MONTGOMERY
KRASNOFF, MD, SIDNEY O	PHILADELPHIA
KRATZ, MD, RONALD D	DAUPHIN
KRATZ, MD, VERNON H	BUCKS
KRAULAND, MD, JOHN E	CAMBRIA
KRAUS, MD, DAVID R	ALLEGHENY
KRAUS, MD, JOHN F	FAYETTE
KRAUS, MD, JOHN J	CHESTER
KRAUS, MD, RICHARD E	YORK
KRAUS, MD, THEODORE J	PHILADELPHIA
KRAUSE, MD, HELEN F	ALLEGHENY
KRAUSE, MD, MARILYN	PHILADELPHIA
KRAUSE, MD, NORMAN M	ALLEGHENY
KRAUSE, MD, ROBERT E	LACKAWANNA
KRAUSE, MD, ROBERT L	PHILADELPHIA
KRAUSE, MD, SEYMOURE	ALLEGHENY
KRAUSER, MD, RONALD E	CHESTER
KRAUSZ, MD, MARTIN R	PHILADELPHIA
KRAVIS, MD, LILLIAN P	MONTGOMERY
KRAVITZ, MD, BERNARD J	MONTGOMERY
KRAVITZ, MD, CHARLES H	PHILADELPHIA
KRAVITZ, MD, KEVIN D	PHILADELPHIA
KRAVITZ, MD, RICHARD M	PHILADELPHIA
KRAWET, MD, STEVEN H	PHILADELPHIA
KRAYBILL, MD, HAROLD E	LEBANON
KRAYBILL, MD, LEON S	LANCASTER
KRAYER JR, MD, NICHOLAS H	BEAVER
KRAYNAK, MD, JOSEPH C	MONTGOMERY
KRAYNICK, MD, BENJAMIN M	LEHIGH
KRCH, MD, MARILYN B	MONTGOMERY
KREBS, MD, JAMES A	ALLEGHENY
KREBS, MD, STEPHEN J	CUMBERLAND
KREEK JR, ANDREW E	STUDENT
KREGER, MD, SPENCER	CAMBRIA
KREIDER, MD, EDWARD E	LEBANON
KREIDER, MD, HENRY L	LANCASTER
KREIDER, MD, JOHN K	LANCASTER
KREIDER, MD, JOHN W	DAUPHIN
KREIDER, MD, KATHLEEN A	LANCASTER
KREINBROOK, MD, SUZANNE B	ALLEGHENY
KREITHEN, MD, HAROLD	LEHIGH
KRELL, MD, ARTHUR S	CAMBRIA
KRELL, MD, HEATHER V	PHILADELPHIA
KREMENS, MD, VICTOR	PHILADELPHIA
KREMER, MD, FREDERIC B	PHILADELPHIA
KREMER, MD, HOWARD U	PHILADELPHIA
KREMER JR, MD, EDWIN S	ERIE
KREMSER, MD, CHARLES A	ALLEGHENY
KRENZEL, MD, ARCHIBALD R	PHILADELPHIA
KRESH, MD, NORMAN N	ALLEGHENY
KRESOCK JR, MD, FRANK D	COLUMBIA
KRESPAN, MD, CHARLES B	LANCASTER
KRESSLER, MD, ROBERT J	PHILADELPHIA
KRETZING, MD, HAROLD G	CUMBERLAND
KREULEN, MD, THOMAS H	PHILADELPHIA
KREUZBURG, MD, ROBERT C	COLUMBIA
KRICH, MD, KAREN L	MONTGOMERY
KRICK, MD, ANDREW E	BUCKS
KRIEBEL, MD, DOROTHY E	BERKS
KRIEBEL, MD, RICHARD H	BUCKS
KRIEDMAN, MD, TERRY F	PHILADELPHIA
KRIEGER, MD, BENSON	PHILADELPHIA
KRIEGER, MD, HARRY L	NORTHAMPTON
KRIFCHER, MD, CHARLES	ALLEGHENY
KRIFCHER, MD, EMANUEL	ALLEGHENY
KRING, MD, CARROLL S	BERKS
KRIPKE, MD, SCOTT A	CHESTER
KRISANDA, MD, JOSEPH B	LACKAWANNA
KRISCH, MD, RONALD A	LEHIGH
KRISHER, STACY L	STUDENT
KRISHNA, MD, BHUPENDRA	CHESTER
KRISHNA, MD, NARENDRA	CHESTER
KRISHNAGIRI, MD, SARALA	PHILADELPHIA
KRISHNAN, MD, GEETA	COLUMBIA
KRISHNAN, MD, KALYAN S	MONTOUR
KRISHNAN, MD, R G	WASHINGTON
KRISHNAN, MD, SHANTI	CHESTER
KRISHNAPPA, MD, BORIAH N	WESTMORELAND
KRISHNASWAMI, MD, SUBRAMANIA	ALLEGHENY
KRISHNASWAMI, MD, V	ALLEGHENY
KRISKY, DAVID M	STUDENT
KRISSINGER, MD, ROBERT C	LANCASTER
KRISTOFIC, MD, JOHN D	ALLEGHENY
KRIVENKO, MD, CHARLES A	LUZERNE
KRIVINKO, MD, DENNIS M	ALLEGHENY
KRIZA, KAREN L	STUDENT
KRIZAR, MD, STEPHEN L	LYCOMING
KROH, MD, DEAN F	WASHINGTON
KROHNER, DO, ROBERT G	ALLEGHENY
KROL, MD, RONALD C	BERKS
KROLL, MD, ALAN D	ALLEGHENY
KROLL, MD, BARRY S	PHILADELPHIA
KROMASH, MD, MARVIN H	MONTGOMERY
KRON, MD, KENNETH M	PHILADELPHIA
KRON, MD, SAMUEL D	PHILADELPHIA
KRONENWETTER, MD, LOIS A	LANCASTER
KROONEN, MD, LISA M	STUDENT
KROOP, MD, HOWARD S	PHILADELPHIA
KROPINICKI, MD, WILLIAM C	BUCKS
KROSER, JONATHAN M	STUDENT
KROSER, MD, JOYANN A	PHILADELPHIA
KROSER, MD, LILA S	PHILADELPHIA
KROSNOFF, MD, MICHAEL	WASHINGTON
KROSS, MD, DEAN E	ALLEGHENY
KROTEC, MD, JOSEPH W	ALLEGHENY
KROUSE, MD, JOHN M	WESTMORELAND
KROUSE, MD, THEODORE B	PHILADELPHIA
KROUSKOP, MD, ANDREW C	ALLEGHENY
KRUGH, MD, FRANCIS J	ALLEGHENY
KRUGH, MD, JAMES W	ALLEGHENY
KRULEWSKI, MD, THOMAS F	LANCASTER
KRUM, DO, SETH D	ERIE
KRUPER, MD, JOHN S	YORK
KRUSEN, MD, DAVID E	LANCASTER
KRUSZEWSKI, DO, DAVID M	ERIE
KRUSZEWSKI, DO, MARY C	JEFFERSON
KRUSZEWSKI, MD, STEFAN P	SCHUYLKILL
KRYWICKI, MD, WILLIAM J	LUZERNE
KRZEMINSKI, MD, JOSEPH P	MONTGOMERY
KSHATRI, MD, ATULKUMAR M	DAUPHIN
KUBACKI, MD, JOSEPH J	BERKS
KUBEK, PERRY B	STUDENT
KUBER, MD, MATTHEW E	PHILADELPHIA
KUBER, MD, MATTHEW T	WAYNE/PIKE
KUBICKA, MD, KURT T	BLAIR
KUBIK, MD, CAROLYN J	ALLEGHENY
KUCER, MD, FRANK T	BUCKS
KUCER, MD, KATHLEEN A	BUCKS
KUCERA, MD, RICHARD F	WESTMORELAND
KUCEWICZ-KOPYTA, MD, BARBARA E	NORTHAMPTON
KUCHARCZUK, MD, JOHN B	LEHIGH
KUCHARCZUK, MD, JOHN C	LEHIGH
KUCHEMBA, MD, LEONARD A	LUZERNE
KUDVA, MD, VIDYA B	ERIE
KUEHNER, DO, P DENIS	LEHIGH
KUGLER, JOSHUA N	STUDENT
KUHLENGEL, MD, BARBARA G	DAUPHIN
KUHLENGEL, MD, KEITH R	DAUPHIN
KUHN, MD, MARK D	BUCKS
KUHN, MD, RICHARD H	ERIE
KUHNEN, MD, WALTER H	WARREN
KUHNERT, MD, PAUL M	MONTGOMERY
KUHNS, MD, STACEY J	YORK
KUKLINSKI, MD, LAWRENCE M	ERIE
KUKORA, MD, JOHN S	MONTGOMERY
KUKRIKA, MD, MIODRAG D	YORK
KULCZYCKI, MD, EDWARD	BRADFORD
KULKARNI, MD, PRADEEP K	CAMBRIA
KULKARNI, SWATI	STUDENT
KULL, MD, RICHARD K	BEAVER
KULP-HUGUES, MD, DEBORAH A	MONTGOMERY
KUMAR, MD, ASHOK	WASHINGTON
KUMAR, MD, HARINATH V	VENANGO
KUMAR, MD, HEMA V	WESTMORELAND
KUMAR, MD, MYSORE S A	PHILADELPHIA
KUMAR, MD, PRADEEP	WESTMORELAND
KUMAR, MD, PREM	BUTLER
KUMAR, MD, RAKESH	ALLEGHENY
KUMAR, MD, SHASHI	ALLEGHENY
KUMAR, MD, SHASHI L	PHILADELPHIA
KUMAR, MD, VASANTHA R	FRANKLIN
KUMAR, MD, VEERANDRA	PHILADELPHIA
KUN, MD, JOSEPH	ALLEGHENY
KUNDA, MD, GOPAL D	WESTMORELAND
KUNDU, MD, SAMBHU N	DAUPHIN
KUNIS, MD, CHRIS C W	FRANKLIN
KUNKEL, MD, BARBARA K	DAUPHIN
KUNKEL, MD, FRANK A	BLAIR
KUNKEL, MD, GEORGE W	DAUPHIN
KUNKEL, MD, HERBERT G	ALLEGHENY
KUNKEL, MD, JAMES V	ALLEGHENY
KUNKEL, MD, MARY E	FAYETTE
KUNKEL, MD, W MINSTER	DAUPHIN
KUNKEL, MD, WILLIAM H	ALLEGHENY
KUNKEL JR, MD, HERBERT G	ALLEGHENY
KUNKLE JR, MD, HERBERT L	CENTRE
KUNSCHNER, MD, ALAN J	ALLEGHENY
KUNSCHNER, MD, ALBERT J	ALLEGHENY
KUNSCHNER, MD, LARA J	STUDENT
KUNSMAN, MD, WILLIAM E	ALLEGHENY
KUNZ, MD, GREGORY J	LEHIGH
KUPERMAN, MD, JULIO L	PHILADELPHIA
KUPERSMITH, MD, STEPHEN J	BUCKS
KUPFER, MD, SAMUEL	ALLEGHENY
KUPREVICH, DO, WILLIAM J	COLUMBIA
KURBAN, MD, RAMSAY S	LEBANON
KURDZIEL, KAREN A	STUDENT
KUREISHY, MD, ZAVEEN A	ALLEGHENY
KUREK JR, DO, STANLEY J	CAMBRIA
KURELLO, MD, PHILLIP J	LUZERNE
KUREMSKY, MD, DALE A	ALLEGHENY
KUREY, MD, PAMELA H	MONTGOMERY
KURIC, MD, KEVIN M	ERIE
KURJANOWICZ, MD, WADIM	BERKS
KUROKI, MD, HELEN M	PHILADELPHIA
KURTH, MD, CHARLES D	PHILADELPHIA
KURTZ, MD, ADELLE G	YORK
KURTZ, MD, ALFRED B	PHILADELPHIA
KURTZ, MD, CHRISTOPHER A	ALLEGHENY
KURTZ, MD, J STEPHEN	PHILADELPHIA
KURTZ, MD, JAMES W	CHESTER
KURTZ, MD, JOHN E	ALLEGHENY
KURTZ, MD, ROBERT M	DELAWARE
KURTZ, MD, ROSA T	DELAWARE
KURZ, MD, RICHARD B	YORK
KURZ, MD, SUSAN D	YORK
KURZWEIL, MD, STEVEN J	LUZERNE
KUSH, MD, FRANK H	ALLEGHENY
KUSH, MD, MARGARET B	ALLEGHENY
KUSH, MD, MICHAEL J	JEFFERSON
KUSHNER, MD, DONALD A	ALLEGHENY
KUSHNER, MD, LOIS N	YORK
KUSHNER JR, MD, GEORGE	YORK
KUSIAK, MD, JOSEPH F	PHILADELPHIA
KUSIAK, MD, VICTORIA M	PHILADELPHIA
KUSKIN, MD, LOUIS F	DAUPHIN
KUSSMAUL, MD, WILLIAM G	PHILADELPHIA
KUTCH, MD, JAMES D	WAYNE/PIKE
KUTNER, MD, BARRY N	BUCKS

KUTSCHER, MD, HARLAN A	BERKS
KUTSENKOW, MD, MICHAEL	ALLEGHENY
KUTZ, MD, CHARLES M	CLARION
KUTZ, MD, TIMOTHY J	BERKS
KUWAHARA, RAYMOND T	STUDENT
KUWIK, MD, RICHARD J	ALLEGHENY
KUZMA JR, MD, PAUL M	BEAVER
KWA, MD, DANIEL M	PHILADELPHIA
KWIAT, MD, MICHAEL A	BEAVER
KWOK, MD, MOODY	STUDENT
KWON, MD, JONG D	BLAIR
KYLE, MD, G CLAYTON	PHILADELPHIA
KYLE, URSULA A	STUDENT
KYREAGES, MD, CONSTANTINE G	ALLEGHENY
KYRIACOPOULOS, MD, JOHN D	ALLEGHENY
KYRIAZI, MD, NICHOLAS C	LEHIGH
L	
LA CAPRA, MD, SAMUEL	PHILADELPHIA
LA NASA, MD, SALVATORE	ALLEGHENY
LABARBERA, MD, ANTHONY P	ALLEGHENY
LABBATE, MD, VICTOR A	LUZERNE
LABE, MD, ALEXANDER	PHILADELPHIA
LABELLE, MD, PATRICE	MONTGOMERY
LABKOFF, MD, STEVEN E	PHILADELPHIA
LABORDA, MD, OSCAR E	DELAWARE
LABORDE, MD, ANDREA T	PHILADELPHIA
LABOWSKIE, MD, EUGENE M	MONTGOMERY
LABUDA, DO, BRYAN E	WESTMORELAND
LABUDA II, MD, JOSEPH M	FAYETTE
LABUSKI, MD, MARK R	INDIANA
LACAVARO, MD, JULES A	DELAWARE
LACE, MD, THOMAS E	WESTMORELAND
LACEY, MD, PAUL G	DAUPHIN
LACHMAN, MD, JOSEPH	DELAWARE
LACOUTURE, MD, LUIS	ALLEGHENY
LACY, THOMAS H	STUDENT
LADANI, MD, CHHAGANLAL D	ALLEGHENY
LADENHEIM, MD, STEVEN E	PHILADELPHIA
LADO, MD, MICHAEL	SCHUYLKILL
LAFER, MD, EDMUND L	PHILADELPHIA
LAFFERTY, MD, THOMAS E	PHILADELPHIA
LAFFEY, MD, PATRICIA A	CHESTER
LAFKAS, MICHAEL P	STUDENT
LAFONTANT, MD, RAYMOND F	PHILADELPHIA
LAFONTANT, MD, ROBERT R	WESTMORELAND
LAGNESE, MD, MARGARET J	ALLEGHENY
LAHAV, MD, ERIKA	NORTHAMPTON
LAHUE-MORDY, DO, RHONDA L	MONTGOMERY
LAI, JERRY JEOU-JU	STUDENT
LAI, MD, KA-SIU	ALLEGHENY
LAI, MD, NALINE L	STUDENT
LAIBSON, MD, PETER R	PHILADELPHIA
LAIGON, MD, EUGENE E	CARBON
LAING, MD, JOHN W	FRANKLIN
LAING, MD, PATRICK G	ALLEGHENY
LAIZER, MD, JANET T	ALLEGHENY
LAKATA, DO, THOMAS J	MONTGOMERY
LAKDAWALA, MD, SHABBIR	ALLEGHENY
LAKSHMIN, MD, MURALI	BERKS
LAL, DO, ROBY A	ALLEGHENY
LALI, MD, M DAVID	PHILADELPHIA
LALLI, MD, JOANNE M	LYCOMING
LALLY, MD, FRANCIS L	ALLEGHENY
LALLY, MD, MICHAEL E	ALLEGHENY
LALLY, MD, PATRICK T	WESTMORELAND
LAM, MD, ALLISON C	STUDENT
LAM, MD, CARL A	LEHIGH
LAMADE, MD, CHARLES D	LYCOMING
LAMAN, ANDREW D	STUDENT
LAMAN, MD, DAVID	ALLEGHENY
LAMANNA, MD, JOHN V	BERKS
LAMARQUE, MD, EDWARD E	DAUPHIN
LAMAS, MD, CARLOS C	ERIE
LAMB, MD, KATHLEEN G	ALLEGHENY
LAMBE, MD, HELEN A	LEHIGH
LAMBERG, MD, RANDY E	MONTGOMERY
LAMBERT, MD, BARBARA A	PHILADELPHIA
LAMBERT, MD, KENNETH P	BERKS
LAMBERT, MD, ROBERT L	PHILADELPHIA
LAMBERTI, MD, WILLIAM F	LACKAWANNA
LAMBERTON, MD, WILLIAM D	ERIE
LAMBERTON, MD, WILLIAM F	ERIE
LAMBERTSEN, MD, CHRISTIAN J	PHILADELPHIA
LAMBIOTTE, MD, CHARLES O	ALLEGHENY
LAME, MD, EDWIN L	PHILADELPHIA
LAMONTE, MD, MARIAN P	PHILADELPHIA
LAMP, MD, ALBERT L	ERIE
LAMP JR, MD, CLYDE B	ALLEGHENY
LAMPARTER, MD, CAROL M	UNION
LAMPE II, MD, WILLIAM T	YORK
LAMSBACK, MD, EDWARD G	PHILADELPHIA
LAN, MD, VICTOR S	INDIANA
LANAUZE, MD, HARRY E	ALLEGHENY
LANCASTER, MD, STEWART L	BEAVER
LANCASTER JR, MD, EDWARD L	LANCASTER
LANCHONEY, THOMAS F	STUDENT
LANCIANO, MD, RACHELLE M	PHILADELPHIA
LANDAU, MD, LEO W	LUZERNE
LANDAU, MD, PHILIP M	ALLEGHENY
LANDAY, MD, RONALD A	ALLEGHENY
LANDEFELD, RALPH N	STUDENT
LANDER, MD, JEFFREY R	YORK
LANDER, MD, WILLIAM W	MONTGOMERY
LANDERMAN, MD, NATHANIEL S	ALLEGHENY
LANDES, MD, RAY P	BUCKS
LANDFAIR, MD, ROY J	ALLEGHENY
LANDIS, MD, FLOYD M	LANCASTER
LANDIS, MD, ROBERT C	YORK
LANDIS, MD, TIMOTHY D	ALLEGHENY
LANDIS, MD, WILLIAM A	YORK
LANDIS JR, MD, JAMES P	ALLEGHENY
LANDON JR, MD, LYNDON H	ALLEGHENY
LANE, MD, BARBARA	BUCKS
LANE, MD, JOHN D	BUCKS
LANE, MD, JOHN F	WASHINGTON
LANE, MD, SALLY D	PHILADELPHIA
LANE, WENDY W	STUDENT
LANG, MD, DAVID F	ALLEGHENY
LANG, MD, GREGORY M	LEHIGH
LANG, MD, HOWARD N	ALLEGHENY
LANG, MD, KAREN A	WESTMORELAND
LANG, MD, NIKKI	PHILADELPHIA
LANGA, MD, VICTORIA M	ALLEGHENY
LANGAN III, MD, E LAWRENCE	DELAWARE
LANGDON, MD, DAVID R	MONTOUR
LANGE, MD, BEVERLY J	PHILADELPHIA
LANGE, MD, MARIANNE K	NORTHAMPTON
LANGER, MD, BURTON H	MONTGOMERY
LANGER, MD, D MORTON	YORK
LANGIERI, MD, GARY	PHILADELPHIA
LANGLOTZ, MD, CURTIS P	PHILADELPHIA
LANGOL JR, MD, GEORGE	ALLEGHENY
LANGRALL, MD, HARRISON M	CHESTER
LANIGAN, MD, CHRISTINE J	PHILADELPHIA
LANKFORD, MD, SCOTT P	YORK
LANNING, MD, RICHARD C	DAUPHIN
LANOCE, MD, LOUIS F	PHILADELPHIA
LANPHER, MD, GREGORY B	YORK
LANSING, MD, DOROTHY I	CHESTER
LANTELME, MD, BRUCE E	LYCOMING
LANTZOUNI, MD, ELENI	PHILADELPHIA
LANZ, MD, RICHARD K	ALLEGHENY
LANZ JR, MD, ROBERT J	ALLEGHENY
LANZA, MD, DONALD C	PHILADELPHIA
LANZA, MD, RALPH A	CHESTER
LANZILLO, MD, JOSEPH H	LANCASTER
LAPAT, MD, RICHARD C	PHILADELPHIA
LAPAYOWKER, MD, MARC S	PHILADELPHIA
LAPERLE, MD, MARGARET M	PHILADELPHIA
LAPES, MD, GEORGE A	YORK
LAPORTA, MD, EDWARD W	DELAWARE
LAPORTE, MD, STEVEN M	CHESTER
LAPOS, MD, LINDA L	LEHIGH
LAPP, MD, FREDERICK C	LYCOMING
LAPUZ, MD, ELSA D	ALLEGHENY
LARACH, MD, DAVID R	DAUPHIN
LAREAU, MD, DANIEL G	WARREN
LAREAU, MD, LAWRENCE G	WARREN
LARGE, MD, FRED D	WASHINGTON
LARGE, MD, HIRAM S	NORTHAMPTON
LARGOZA, MD, NACIANCENO T	PHILADELPHIA
LARICCIA, MD, PATRICK J	PHILADELPHIA
LARKIN, MD, FRANCIS L	FAYETTE
LARKIN, DO, MICHAEL J	MONTOUR
LARKIN, MD, WILLIAM A	FAYETTE
LARKIN JR, MD, MICHAEL J	LAWRENCE
LARKIN JR, MD, VINCENT D	LACKAWANNA
LARKIN JR, MD, WALTER J	LACKAWANNA
LAROCHE, MD, ROGER R	MCKEAN
LAROCHELLE, MD, ANNE G	CRAWFORD
LAROCHELLE JR, MD, GERALD E	CRAWFORD
LAROSSA, MD, DONATO D	PHILADELPHIA
LARSON, MD, CHRISTOPHER E	ALLEGHENY
LARSON, MD, ELEANOR	TIOGA
LARSON, MD, THOMAS J	ALLEGHENY
LARSON JR, MD, THEODORE S	LYCOMING
LARSSON, MD, ERNST O	LUZERNE
LASALVIA, MD, LUCY A	PHILADELPHIA
LASHER, MD, J DONALD	ERIE
LASHER, MD, ROBERT L	ERIE
LASHER, MD, SUSAN MOORE	ERIE
LASKAS, CLAIRE A	STUDENT
LASKAS, MD, JOHN J	DELAWARE
LASKAS JR, MD, JOHN J	DELAWARE
LASORDA, DO, DAVID M	ALLEGHENY
LAST, MD, JOEL I	WESTMORELAND
LATMAN, MD, STEPHEN F	BERKS
LATOFF, MD, THOMAS J	CHESTER
LATSHAW, MD, ROBERT F	LANCASTER
LATTA, MD, RICHARD A	MONTGOMERY
LATTANZI, MD, DANIEL R	ALLEGHENY
LATTARI, MD, VINCENT A	ALLEGHENY
LATTIMER, MD, GARY L	LYCOMING
LATTIN, MD, GARY M	BERKS
LATUSKA, MD, RICHARD F	ALLEGHENY
LAU, MD, HAR CHI	PHILADELPHIA
LAU, MD, HENRY T	PHILADELPHIA
LAUANDOS, MD, IBRAHIM E	BUCKS
LAUB, MD, CURTIS H	CRAWFORD
LAUBACH, MD, GEORGE B	NORTHAMPTON
LAUBACH JR, MD, CHARLES A	MONTOUR
LAUCIUS, MD, J FREDERICK	PHILADELPHIA
LAUCKS, MD, STEPHEN O	YORK
LAUCKS II, MD, SAMUEL S	YORK
LAUCKS JR, MD, STANLEY P	YORK
LAUDENSLAGER, MD, ELMER C	BUCKS
LAUER, MD, CARL G	ERIE
LAUER, MD, JAMES H	BEAVER
LAUERMAN, MD, WILLIAM C	ALLEGHENY
LAUFE, MD, MARC D	ALLEGHENY
LAUGHINGHOUSE, MD, KENNETH A	PHILADELPHIA
LAUGHNER, DO, JAMES P	MONTOUR
LAUKAITIS, MD, RONALD B	LANCASTER
LAURO, MD, GREGORY R	WESTMORELAND
LAURY, MD, WILLIAM L	PHILADELPHIA
LAUTER, MD, O SCOTT	LANCASTER
LAUTZ, MD, VIRGINIA H	PHILADELPHIA
LAUZONIS, MD, PETER W	LUZERNE
LAVAN, MD, DONALD W	PHILADELPHIA
LAVELLE, MD, JANE M	PHILADELPHIA
LAVERAN, MD, RUDOLF L	YORK
LAVERAN STIEBER, MD, RUDOLF F	PHILADELPHIA
LAVERDE, MD, PHILIP S	VENANGO
LAVIETES, MD, WILLIAM P	YORK
LAVIN-LESKA, MD, LINDA S	BUCKS
LAVRICH, MD, JUDITH B	BUCKS
LAW, MD, STUART C	ALLEGHENY
LAWLESS, MD, GRANT D	ALLEGHENY
LAWLOR, MD, MAUREEN	ALLEGHENY
LAWLOR, MD, ROBERT J	MONTGOMERY
LAWRENCE, CHERYL I	STUDENT
LAWRENCE, MD, JAMES B	PHILADELPHIA
LAWRENCE, MD, JODY	PHILADELPHIA
LAWRENCE, MD, JOHN W	DELAWARE
LAWRENCE, MD, PHILIP H	MONROE
LAWRENCE, MD, ROBINA R	YORK
LAWRENCE, MD, STEVEN J	LEHIGH
LAWRENCE IV, MD, AUGUSTINE H	PHILADELPHIA
LAWSKY, MD, ALAN R	ALLEGHENY
LAWSON JR, MD, HERMAN	DAUPHIN
LAYCHOCK, MD, ANNA M	SCHUYLKILL
LAYDEN, MD, PAUL W	ERIE
LAYNE, MD, GEORGE S	LEHIGH
LAZAR, MD, JEFFREY C	MERCER
LAZARO MORAN, MD, MIGUELA D	PHILADELPHIA
LAZARUS, DO, BEN G	LANCASTER
LAZORIK, MD, FRANCIS C	DELAWARE
LAZZARA, MD, ROBERT R	ALLEGHENY
LAZZARO, MD, THEODORE A	WESTMORELAND
LE, MD, DUC T	YORK
LE, HOANG T	STUDENT
LE, DO, KHOI D	PHILADELPHIA
LE, LARA	STUDENT
LE BON, FENTON G	STUDENT
LEAHEY, MD, ALAN B	LEHIGH
LEAHEY, MD, ANN MARIE	PHILADELPHIA
LEAHY, MD, JOANN M	BUCKS
LEAL, MD, GUMERSINDO R	SCHUYLKILL
LEAMAN, MD, IVAN B	LANCASTER
LEAMAN, MD, PHYLLIS L	LANCASTER
LEAMAN, MD, THOMAS L	DAUPHIN
LEANZ, MD, GARY F	CUMBERLAND
LEAR, MD, WILLIAM L	INDIANA
LEARNER, MD, NORMAN	PHILADELPHIA
LEASE, MD, JOHN R	LUZERNE
LEASER, MD, JOSEPH P	DAUPHIN
LEASURE, MD, NICK C	BERKS
LEATHERS, MD, DONALD J	LYCOMING
LEAVENS, MD, HUGH M	DAUPHIN
LEAVITT, MD, HERBERT M	NORTHAMPTON
LEAVITT, DO, RICHARD JAY	PHILADELPHIA
LEBER, MD, DAVID C	DAUPHIN
LEBER, MD, PAUL E	LYCOMING
LEBERMAN, MD, PAUL R	PHILADELPHIA
LEBISCHAK, MD, H CAROL	LANCASTER
LEBOEUF, MD, WILLIAM L	LEHIGH
LEBOUITZ, MD, STANTON S	YORK
LEBOVITZ, BRIAN L	STUDENT
LEBOVITZ, MD, CHARLES N	ALLEGHENY
LEBOVITZ, MD, JEROME J	ALLEGHENY
LECAVALIER, MD, LARRY A	BUCKS
LECHMANICK, MD, EUGENE A	ALLEGHENY
LECHTZIN, NOAH	STUDENT
LECKEY, RONALD D	STUDENT
LECKS, MD, LEONARD E	PHILADELPHIA
LEDDY, MD, CHERYL	PHILADELPHIA
LEDER, MD, DAVID S	PHILADELPHIA
LEDESMA, MD, ELIHU J	PHILADELPHIA
LEDIS, MD, SEYMOUR	BUCKS
LEE, MD, ALBERT C	CLEARFIELD
LEE, MD, AUNG P	ERIE
LEE, MD, BERNARD L	PHILADELPHIA
LEE, MD, CHANCHI	BUCKS
LEE, MD, CHARLES Y	DELAWARE
LEE, MD, CHONG S	NORTHAMPTON
LEE, MD, CHUNG H	CARBON
LEE, MD, DANIEL	CHESTER
LEE, MD, DAVID R	FRANKLIN
LEE, MD, EDWARD W	PHILADELPHIA
LEE, MD, EDWARD Y	LACKAWANNA
LEE, MD, EDWIN N	LEHIGH
LEE, MD, FOO T	ALLEGHENY
LEE, MD, GUY A	PHILADELPHIA
LEE, MD, H C	NORTHAMPTON
LEE, MD, HOWARD J	BUCKS
LEE, MD, HYUN-JOO	PHILADELPHIA
LEE, MD, IN W	ERIE
LEE, JAMES	STUDENT
LEE, MD, JANGWOO	SCHUYLKILL
LEE, MD, JOHN KEUN-SANG	ALLEGHENY
LEE, JONG O	STUDENT
LEE, MD, JONG Y	WESTMORELAND
LEE, MD, JOSEPH I	PHILADELPHIA
LEE, MD, JOSEPH S	DELAWARE
LEE, MD, JUNG-PIL	BERKS
LEE, MD, KANG S	BLAIR
LEE, MD, KENNETH K	HUNTINGDON
LEE, MD, KI B	LUZERNE
LEE, MD, KUK S	FAYETTE
LEE, MD, KWAN I	ALLEGHENY
LEE, MD, KWANG W	PHILADELPHIA
LEE, MD, KYUNG C	LACKAWANNA
LEE, MD, MARTIN L	MONTOUR
LEE, DO, MICHAEL D	ALLEGHENY
LEE, MD, MONIKA G	DAUPHIN
LEE, MD, OOK J	ALLEGHENY
LEE, PETER P	STUDENT
LEE, MD, ROBERT E	ALLEGHENY
LEE, MD, ROTAN	PHILADELPHIA
LEE, MD, SANG E	ALLEGHENY
LEE, MD, SANG T	NORTHAMPTON
LEE, DO, SARAH C	NORTHAMPTON
LEE, SUSIE I	STUDENT
LEE, MD, W ROBERT	PHILADELPHIA
LEE, MD, WILLIAM	ALLEGHENY
LEE, MD, WILLIAM M	MONTGOMERY
LEE, MD, WON Y	SCHUYLKILL
LEE, MD, YI-CHUN	PHILADELPHIA
LEE, MD, YOUNG W	WAYNE/PIKE
LEE JR, MD, CHARLES T	PHILADELPHIA
LEE JR, MD, JAMES H	PHILADELPHIA
LEECH JR, MD, JOHN E	MONTOUR
LEEGARD, MD, ROBERT L	PHILADELPHIA
LEEHAN, MD, SEAN W	ALLEGHENY
LEEN, MD, RAYMOND L	ALLEGHENY
LEERS, MD, STEVEN A	ALLEGHENY
LEET, MD, THOMAS E	LEHIGH
LEFEVER, MD, ROBERT S	ADAMS
LEFF, MD, BERNARD	ALLEGHENY
LEFF, DO, DAVID A	NORTHAMPTON
LEFKOE, MD, ROY T	PHILADELPHIA
LEFTON, MD, HARVEY B	PHILADELPHIA
LEGENDRE, MD, GERALD M	MONTGOMERY
LEGERE, DO, JOHN B	LANCASTER
LEHMAN, MD, CLINTON J	LUZERNE
LEHMAN, DO, GREGORY M	DELAWARE
LEHMAN, MD, JOHN W	BEAVER
LEHMAN, MD, JULIA F	CAMBRIA
LEHMAN, MD, RALPH A	DAUPHIN
LEHMAN, MD, RUBY V	DAUPHIN
LEHMAN JR, NORMAN L	STUDENT
LEHMANN, MD, DAVID C	PHILADELPHIA
LEHRER, MD, LEWIS	PHILADELPHIA
LEHRER, MICHAEL S	STUDENT
LEHRICH, MD, HENRY E	LEHIGH
LEIB, MD, PAMELA L	SCHUYLKILL
LEIB JR, MD, RICHARD C	CAMBRIA
LEIBENSPERGER, MD, STEPHEN N	ALLEGHENY
LEIBMAN, MD, JOSEPH B	LACKAWANNA
LEIBOLD, MD, DEBRA M	MONTGOMERY
LEIBOWITZ, MD, ARTHUR N	DELAWARE
LEIBOWITZ, MD, LEONARD D	ALLEGHENY
LEIBY, MD, DAVID K	BUCKS
LEIFER, JOSHUA M	STUDENT
LEIGH, MD, FLORA B	DELAWARE
LEIGH, MD, REWNG	WESTMORELAND
LEIGHTON JR, MD, JOHN C	PHILADELPHIA
LEIGHTY, MD, RALPH G	SOMERSET
LEIMAN, MD, PAUL M	LACKAWANNA
LEINBERRY, MD, CHARLES F	BERKS
LEINWEBER, MD, BRUCE K	PHILADELPHIA
LEIPHART, MD, CLARENCE D	LANCASTER
LEIS, MD, DEAN J	DAUPHIN
LEISAWITZ, MD, ELLIOTT G	BERKS
LEISAWITZ, MD, PAUL A	BERKS
LEISE, MD, ELEANOR O	DELAWARE
LEISER, MD, JONATHON B	PHILADELPHIA
LEISTER, MD, GLENN F	YORK
LEISTER, MD, HOWARD A	BUCKS
LEITAO, MD, EDWARD A	ALLEGHENY
LEITEL, MD, HAROLD L	JEFFERSON
LEKACH, MD, JACUB	LACKAWANNA
LEKAWA, MD, THADDEUS	YORK
LEKE, MD, MICHAEL A	PHILADELPHIA
LELE, MD, PRAMOD S	DELAWARE
LEMAN, MD, WILLIAM W	DELAWARE
LEMASTERS, DO, THOMAS R	SCHUYLKILL
LEMASTERS, DO, WILLIAM C	NORTHMBRLAND
LEMAY, MD, MICHELE L	PHILADELPHIA
LEMBERG, MD, JEFFREY D	ALLEGHENY
LEMENTOWSKI, MD, MICHAL	FAYETTE
LEMERT, MD, MICHAEL R	CHESTER
LEMIS, MD, PETER M	ALLEGHENY
LEMOLE, MD, GERALD M	PHILADELPHIA
LEMPERT, MD, STEVEN L	ALLEGHENY
LENAHAN, SUSAN E	STUDENT
LENAHAN, MD, TERRENCE P	LACKAWANNA
LENCHNER, MD, GREGORY S	PHILADELPHIA
LENKEY, MD, JOSEPH L	ALLEGHENY
LENNERT, MD, JOSEPH B	NORTHAMPTON
LENOX, MD, CORA C	ALLEGHENY
LENOX, MD, JOHN E	ALLEGHENY
LENROW, MD, DAVID A	MONTGOMERY
LENTINI, MD, J CHARLES	LUZERNE
LENTON, MD, HERBERT P	CUMBERLAND
LENTZ, MD, CONRAD L	NORTHAMPTON
LENTZ, MD, KENNETH H	ALLEGHENY
LENTZ, MD, MARK R	INDIANA
LENTZ, MD, ROBERT E	LEHIGH
LENYO, MD, GEORGE E	SCHUYLKILL
LENZ, PATRICK K	STUDENT
LEO, MD, LOUIS R	PHILADELPHIA
LEON, STUART M	STUDENT
LEONARD, MD, EDWARD H	PHILADELPHIA
LEONARD, DO, M DENICE	ALLEGHENY
LEONARD III, MD, DANIEL J	CAMBRIA
LEONARD JR, MD, EDWARD C	PHILADELPHIA
LEONE, MD, FRANK T	PHILADELPHIA
LEONE, MD, GUY R	WESTMORELAND
LEONE PAK, MD, LISA D	STUDENT
LEONG, MD, MILA A	PHILADELPHIA
LEONG, MD, MIMI	STUDENT
LEONI, MD, JOSEPH	BERKS
LEONIDA, MD, ELFREN L	WESTMORELAND
LEOPOLD, DO, NORMAN A	DELAWARE

LEPAR, MD, EDWIN	PHILADELPHIA
LEPERA, DO, PAMELA A	PHILADELPHIA
LEPIANE, MD, RICHARD M	BEAVER
LEPONE, MD, KENNETH	LEBANON
LERBERG, MD, DAVID B	ALLEGHENY
LERMAN, MD, MICHAEL G	YORK
LERNER, MD, ARTHUR M	PHILADELPHIA
LERNER, MD, HARVEY J	PHILADELPHIA
LERNER, MD, SAMUEL M	LEHIGH
LEROY, MD, N BLAIR	MONTGOMERY
LERTZMAN, MD, BETH H	PHILADELPHIA
LESACA, MD, TIMOTHY G	FAYETTE
LESCANIC, MD, MICHAEL L	CENTRE
LESCHEK, MD, LISA M	STUDENT
LESHNER, DO, RICHARD T	PHILADELPHIA
LESHOCK, MD, LEON E	CARBON
LESKO, DO, MICHAEL G	LANCASTER
LESLIE, MD, DAVID C	WASHINGTON
LESLIE, MD, MARTHA I	STUDENT
LESLIE, MD, PAUL A	LANCASTER
LESLIE JR, MD, M RUSSELL	ALLEGHENY
LESNIAK, MD, JOHN P	LACKAWANNA
LESNOCK, MD, ROBERT G	WASHINGTON
LESSARD, MD, JEAN L	ERIE
LESSE, MD, S MICHAEL	NORTHAMPTON
LESSER, MD, RAYMOND W	PHILADELPHIA
LESSIG, MD, HARRY J	PHILADELPHIA
LESSIG, MD, MARVIN A	PHILADELPHIA
LESTER, MD, MARK C	LEHIGH
LETIZIA, KATHLEEN A	STUDENT
LETO, MD, FRANCESCO	PHILADELPHIA
LETOCHA, MD, CHARLES E	YORK
LETWIN, MD, LEE B	MONTGOMERY
LEUKHARDT, MD, DAVID B	INDIANA
LEUNISSEN, MD, R L ABRAHAM	DELAWARE
LEUTE, MD, MILLARD S	DELAWARE
LEVANDOSKI, MD, DIANE C	LUZERNE
LEVANDOSKI JR, MD, GERALD J	LUZERNE
LEVENBERG, MD, RICHARD J	DELAWARE
LEVENSON, MD, DAVID J	ALLEGHENY
LEVENSON, MD, MORTON W	LANCASTER
LEVENTHAL, MD, LINDA C	BUCKS
LEVETTE, MD, ANDREW R	MONTGOMERY
LEVICK, MD, MARVIN H	ALLEGHENY
LEVICK, MD, STANLEY N	PHILADELPHIA
LEVIEN, MD, DAVID H	PHILADELPHIA
LEVIN, MD, ANDREW J	PHILADELPHIA
LEVIN, MD, BARRY L	PHILADELPHIA
LEVIN, MD, BRADLEY H	YORK
LEVIN, MD, DANIEL M	DAUPHIN
LEVIN, MD, DAVID C	PHILADELPHIA
LEVIN, MD, GARY J	CHESTER
LEVIN, MD, GENE D	BUCKS
LEVIN, MD, HOWARD A	MONTGOMERY
LEVIN, MD, KENNETH	NORTHAMPTON
LEVIN, MD, LARRY L	BUCKS
LEVIN, MD, LESLIE G	PHILADELPHIA
LEVIN, MD, MARC W	LEHIGH
LEVIN, MD, MATTHEW W	ALLEGHENY
LEVIN, MD, MICHAEL D	PHILADELPHIA
LEVIN, MD, MOISEY	BUCKS
LEVIN, DO, MORRIS	BUCKS
LEVIN, MD, NORMAN P	PHILADELPHIA
LEVIN, MD, RICHARD L	BUCKS
LEVIN, MD, RICHARD M	LANCASTER
LEVIN, MD, ROBERT M	BLAIR
LEVIN, MD, RONALD M	PHILADELPHIA
LEVIN, MD, STEVEN P	MONTGOMERY
LEVINE, MD, ALAN P	BERKS
LEVINE, MD, ARNOLD H	PHILADELPHIA
LEVINE, MD, ARTHUR L	LEHIGH
LEVINE, MD, BRUCE D	CAMBRIA
LEVINE, MD, CHARLES B	YORK
LEVINE, MD, CHARLES R	LEHIGH
LEVINE, MD, FREDERICK H	PHILADELPHIA
LEVINE, DO, JEFFREY N	LANCASTER
LEVINE, MD, JOEL I	ADAMS
LEVINE, MD, MACY I	ALLEGHENY
LEVINE, MD, MARK J	ERIE
LEVINE, MD, MICHAEL	ALLEGHENY
LEVINE, MD, MICHAEL G	PHILADELPHIA
LEVINE, MD, PHILLIP R	ALLEGHENY
LEVINE, MD, RICHARD B	PHILADELPHIA
LEVINE, MD, SHELDON R	ALLEGHENY
LEVINSKY, MD, WALTER J	PHILADELPHIA
LEVINSON, MD, BRADLEY A	ALLEGHENY
LEVINSON, MD, JULIAN P	ALLEGHENY
LEVINSON, MD, MARK E	DAUPHIN
LEVINSON, MD, PETER G	ERIE
LEVINSON, MD, SANDER J	LACKAWANNA
LEVINSON, MD, STUART L	PHILADELPHIA
LEVINSON, MD, WILLIAM D	WESTMORELAND
LEVIT, MD, EDITHE J	PHILADELPHIA
LEVIT, MD, LAWRENCE S	PHILADELPHIA
LEVIT, MD, SAMUEL M	PHILADELPHIA
LEVITT, MD, JERRY D	PHILADELPHIA
LEVITT, MD, LAWRENCE P	LEHIGH
LEVY, MD, DAVID J	ERIE
LEVY, MD, EDWIN J	DELAWARE
LEVY, MD, JON A	ALLEGHENY
LEVY, MD, LESLIE J	ALLEGHENY
LEVY, MD, MARK M	PHILADELPHIA
LEVY, MD, MARSHALL S	ALLEGHENY
LEVY, MD, MICHAEL H	PHILADELPHIA
LEVY, MD, PAUL F	BERKS
LEVY, MD, REINHARDT D	ALLEGHENY
LEVY, MD, SCOTT S	BUCKS
LEVY, MD, STEVEN A	ERIE
LEVY, MD, SUSAN E	PHILADELPHIA
LEW, MD, CHUNG M	BEAVER
LEWANDOWSKI, MD, ANN E	FRANKLIN
LEWBART, MD, MARVIN L	DELAWARE
LEWIN, MD, JULIAN R	ALLEGHENY
LEWIN, MD, STANLEY B	DAUPHIN
LEWINE, MD, YALE S	CAMBRIA
LEWIS, MD, ALAN E	PHILADELPHIA
LEWIS, MD, DANIEL W	PHILADELPHIA
LEWIS, MD, EARL T	CHESTER
LEWIS, MD, ELAINE R	BERKS
LEWIS, ELDRIN F	STUDENT
LEWIS, MD, GARY W	WESTMORELAND
LEWIS, MD, GREGORY L	CUMBERLAND
LEWIS, MD, HENRY C	WESTMORELAND
LEWIS, MD, JAMES W	PHILADELPHIA
LEWIS, MD, JANET K	UNION
LEWIS, JENNIFER L	STUDENT
LEWIS, MD, JOFFRE P	SCHUYLKILL
LEWIS, DO, KATHLEEN C	LYCOMING
LEWIS, MD, KATHRYN A	BLAIR
LEWIS, MD, L CLIFFORD	CHESTER
LEWIS, MD, MAURICE J	DAUPHIN
LEWIS, NANCY L	STUDENT
LEWIS, MD, PAUL L	PHILADELPHIA
LEWIS, MD, PHILIP G	BUCKS
LEWIS, MD, RICHARD P	ALLEGHENY
LEWIS, MD, ROBERT E	ALLEGHENY
LEWIS, MD, STUART H	DELAWARE
LEWIS, MD, WALTER E	MONTGOMERY
LEWIS, MD, WILLIAM J	DELAWARE
LEWIS JR, MD, GEORGE C	PHILADELPHIA
LEWIS JR, MD, HOWARD T	ALLEGHENY
LEWIS JR, MD, THOMAS J	ALLEGHENY
LEYZIN, MD, FELIX	PHILADELPHIA
LEYZIN, MD, MARA S	PHILADELPHIA
LEZEK, MD, VINCENT J	ALLEGHENY
LIACHOWITZ, MD, CLAIRE H	PHILADELPHIA
LIACOURAS, MD, CHRIS A	PHILADELPHIA
LIANG, MD, DAVID Y	ALLEGHENY
LIANG, MD, GWENDOLYN J	MONTGOMERY
LIANG, MD, JEFFREY Y	BRADFORD
LIANG, MD, MARIA	ALLEGHENY
LIAW, MD, MING T	PHILADELPHIA
LIAW, MD, WEN HAW	PHILADELPHIA
LIAW, DO, WILLIAM J	STUDENT
LIBASSI, MD, MARK J	PHILADELPHIA
LIBELL, DAVID P	STUDENT
LIBERI, MD, ALFRED A	DELAWARE
LIBERTA, MD, THOMAS R	NORTHAMPTON
LICHTENBERG, MD, RICHARD A	DELAWARE
LICHTENSTEIN, MD, ISRAEL	PHILADELPHIA
LICHTENSTEIN, SETH H	STUDENT
LICHTENSTEIN, MD, STEPHEN B	PHILADELPHIA
LICHTER, MD, JAMES G	ALLEGHENY
LICHTMAN, MD, JOSEPH M	PHILADELPHIA
LIDDELL, MD, ALBERT G	LYCOMING
LIDSTON, MD, BRUCE M	HUNTINGDON
LIEB, MD, JOHN G	YORK
LIEBENBERG, MD, ROBERT E	PHILADELPHIA
LIEBENTRITT, MD, FRANK J	CRAWFORD
LIEBER, MD, CLAUDE P	PHILADELPHIA
LIEBER, MD, PAUL S	CENTRE
LIEBERMAN, MD, BRUCE L	BUCKS
LIEBERMAN, MD, DANIEL	PHILADELPHIA
LIEBERMAN, MD, DONALD C	LUZERNE
LIEBERMAN, MD, DONALD H	PHILADELPHIA
LIEBERMAN, MD, FRANCIS A	LEHIGH
LIEBERMAN, MD, GEORGE E	PHILADELPHIA
LIEBERMAN, MD, RICHARD M	LEHIGH
LIEBERMAN, DO, RONALD M	PHILADELPHIA
LIEBERMAN JR, MD, JOSEPH A	LEHIGH
LIEBERT, MD, PAUL L	PHILADELPHIA
LIEBLER, MD, GEORGE A	ALLEGHENY
LIEBMAN, MD, EMIL P	PHILADELPHIA
LIEBMAN, MD, IRVIN M	BUCKS
LIEBREICH, MD, MARK	BUCKS
LIEBROSS, MD, IRA D	LANCASTER
LIEBSON, MD, CHARLES	INDIANA
LIEDERBACH, MD, STEPHEN J	ALLEGHENY
LIEF, MD, HAROLD I	PHILADELPHIA
LIEFELD, MD, PAUL A	ALLEGHENY
LIEN, MD, DONALD C	PHILADELPHIA
LIEN, MD, REY-IN	PHILADELPHIA
LIFTON, STACEY H	STUDENT
LIGGETT, MD, JOHN S	ALLEGHENY
LIGGETT, MD, JOSEPH G	ALLEGHENY
LIGHT, MD, JOHN H	CENTRE
LIGHT, MD, JOHN J B	LEBANON
LIGHT, KAREN J	STUDENT
LIGHT, MD, WILMA C	WESTMORELAND
LIGHTMAN, MD, DAVID A	LYCOMING
LIGHTS, MD, VERNEDA M	PHILADELPHIA
LIGNELLI, MD, GREGORY J	BERKS
LILIENTHAL, MD, DAVID S	ALLEGHENY
LILIK, MD, KENNETH W	LACKAWANNA
LILLEY, MD, EILEEN R	PHILADELPHIA
LILLEY, MD, GEORGE W	DELAWARE
LILLI, MD, ELMO J	MONROE
LILLMARS, DO, STEVEN A	MONTOUR
LILLY, DO, TIMOTHY J	COLUMBIA
LIM, ALEXANDER J	STUDENT
LIM, MD, CHANG-SEIN	WAYNE/PIKE
LIM, MD, DAWSON	ALLEGHENY
LIM, MD, ELIZABETH G	INDIANA
LIM, MD, FELIXBERTO D	ALLEGHENY
LIM, MD, HENG-FENG	DAUPHIN
LIM, MD, LOURDES T	MERCER
LIM, DO, SCOTT J M	ERIE
LIM, MD, YOUNG K	WESTMORELAND
LIM-VILLANUEVA, MD, ROSEMARIE L	BRADFORD
LIMA, MD, CLAUDIO A B	ALLEGHENY
LIMAURO, MD, DAVID L	ALLEGHENY
LIMBERAKIS, MD, ANTHONY J	PHILADELPHIA
LIMBERGER, MD, WILLIAM A	CHESTER
LIMBERT, MD, LAWRENCE	MONTGOMERY
LIMKAKENG, MD, ALEXANDER D	MERCER
LIMOGES, MD, RICHARD F	PHILADELPHIA
LIN, MD, CHING H	SCHUYLKILL
LIN, DEBORAH W	STUDENT
LIN, DWIGHT J	STUDENT
LIN, MD, EDUARDO I T	PHILADELPHIA
LIN, MD, LUKE	ALLEGHENY
LIN, MD, MING-SHEK	ALLEGHENY
LIN, MD, PAUL M	PHILADELPHIA
LIN, MD, PAUL S	UNION
LIN, MD, PU CHING	ELK/CAMERON
LIN, MD, RONG-CHUNG	ALLEGHENY
LIN, MD, SHIOW-BIH	ALLEGHENY
LINCOFF, MD, WILLIAM	DELAWARE
LIND, MD, THOMAS E	MONTOUR
LINDBERG, MD, NICHOLAS O	BUCKS
LINDBLAD, MD, JOHN H	ALLEGHENY
LINDENBAUM, MD, GARY A	DELAWARE
LINDENBAUM, MD, JORGE	ALLEGHENY
LINDENFELD, MD, ARTHUR	LEHIGH
LINDER, MD, LISA J	DELAWARE
LINDER, MD, PAUL G	ALLEGHENY
LINDHOLM, MD, DALE D	LACKAWANNA
LINDHOLM, MD, MARY E	CENTRE
LINDNER, MD, MARIE A	CHESTER
LINDQUIST, MD, JOHN N	PHILADELPHIA
LINDSAY, MD, MARYANNE W	ALLEGHENY
LINE, MD, DENNIS E	CUMBERLAND
LING, MD, CHARLES C	SCHUYLKILL
LING, MD, HENRY T	MONTGOMERY
LINGANNA, MD, BHATTARAHALLY Y	LAWRENCE
LINGARAJU, MD, NAGARAJ	PHILADELPHIA
LINGENFELTER, MD, KYLE A	BRADFORD
LINHART, MD, RANDOLPH W	ALLEGHENY
LININGER, MD, JOHN R	MONTGOMERY
LININGER, MD, MICHAEL D	ALLEGHENY
LINN, DO, ROBERT	PHILADELPHIA
LINN, MD, SHELDON H	LEHIGH
LINNEMANN, MD, ROGER E	PHILADELPHIA
LINS, MD, JEFFREY A	BEAVER
LINTGEN, MD, ARTHUR B	MONTGOMERY
LINTZMEYER, MD, EMIL A	DELAWARE
LIPAPIS, MD, CHRISTY N	ALLEGHENY
LIPES, MD, JAN K	BUCKS
LIPKIN, MD, DAVID E	MONTGOMERY
LIPKIN, DO, HERBERT J	PHILADELPHIA
LIPMAN, MD, BERNARD L	PHILADELPHIA
LIPMAN, MD, RODNEY C	ALLEGHENY
LIPMAN, MD, SIDNEY P	ERIE
LIPNACK, DO, ERIC M	MONTGOMERY
LIPNICK, MD, JESSE A	DELAWARE
LIPPE, MD, RONALD W	DAUPHIN
LIPPERT, MD, LOUIS C	JEFFERSON
LIPPIN, MD, RICHARD A	PHILADELPHIA
LIPPMAN, CALEB R	STUDENT
LIPPO, MD, FRANK L	PHILADELPHIA
LIPSCHUTZ, MD, ARTHUR	PHILADELPHIA
LIPSCHUTZ, MD, LOUIS B	PHILADELPHIA
LIPSCHUTZ, MD, STEVEN M	PHILADELPHIA
LIPSHUTZ, MD, HAROLD	PHILADELPHIA
LIPSITZ, MD, H DAVID	ALLEGHENY
LIPSIUS, MD, EDWARD I	PHILADELPHIA
LIPSON, MD, CHERYL S	CARBON
LIPSON, MD, M BARRY	BUCKS
LIPSON, MD, STEPHEN D	LYCOMING
LIPTON, MD, STEVEN E	MONTGOMERY
LIPUT JR, MD, JOSEPH H	ALLEGHENY
LIRIO, MD, SIXTO M	DELAWARE
LIS, MD, EDWARD T	YORK
LISAN, MD, PHILIP	PHILADELPHIA
LISBERGER, MD, MARK D	DELAWARE
LISI, MD, LOUISE M	PHILADELPHIA
LISKA, MD, JOHN R	WESTMORELAND
LISKER, MD, SHELDON A	PHILADELPHIA
LISNYCZYJ, MD, NICHOLAS	LACKAWANNA
LISOWITZ, MD, GERALD M	WESTMORELAND
LISS, MD, ARTHUR	LUZERNE
LISS, MD, FREDERIC E	LEBANON
LISS, MD, GILBERT A	CHESTER
LISS, MD, JONATHAN	YORK
LISS, DO, KENNETH A	PHILADELPHIA
LISS, MD, ROBERT G	ALLEGHENY
LISS, MD, ROBERT P	CHESTER
LISTA, MD, WILLIAM A	PHILADELPHIA
LISTWA, DO, HOWARD M	LEHIGH
LISZKA, DO, ANNE-MARIE	ERIE
LISZKA II, EDWARD G	STUDENT
LITCHMAN, MD, JOSEPH F	LUZERNE
LITCHMAN, MD, MAUREEN R	LUZERNE
LITMAN, DO, RANDY G	MONTGOMERY
LITOVSKY, MD, DANIEL A	BUCKS
LITRENTA, MD, DAVID E	YORK
LITT, MD, LAWRENCE M	MONTGOMERY
LITTLE, MD, BRIAN W	NORTHAMPTON
LITTLE, MD, G ROBERT	DAUPHIN
LITTLE, MD, ROBERT G	DAUPHIN
LITTLE, MD, THOMAS	NORTHAMPTON
LITTMAN, MD, JEFFREY JAY	PHILADELPHIA
LITTON, ASHLEY D	STUDENT
LITTON, MD, LINDA T	DAUPHIN
LITTS, MD, ALAN W	DAUPHIN
LITVIN, MD, HENRY	MONTGOMERY
LIU, MD, EVAN Y	PHILADELPHIA
LIU, MD, HWAYUE	CAMBRIA
LIU, MD, PHILIP G	WAYNE/PIKE
LIU, MD, ROSITA O	WAYNE/PIKE
LIU, VINCENT	STUDENT
LIVECCHI, MD, JOHN T	LACKAWANNA
LIVENGOOD, MD, MARGARET A	LUZERNE
LIVOLSI, MD, PHILIP D	PHILADELPHIA
LIVORNESE, MD, DOUGLAS S	PHILADELPHIA
LIVORNESE JR, MD, LAWRENCE L	PHILADELPHIA
LIZAK, DO, RICHARD J	LACKAWANNA
LIZANO, MD, VIOLETA M	LACKAWANNA
LLOYD, MD, BENJAMIN J	BERKS
LLOYD, MD, GERALD R	ERIE
LLOYD, MD, JON C	ALLEGHENY
LO, MD, SHIH C	ALLEGHENY
LOBAS, MD, DAVID M	ALLEGHENY
LOBEL, MD, JEFFREY S	MONTOUR
LOBES JR, MD, LOUIS A	ALLEGHENY
LOBITZ, MD, STANLEY A	LUZERNE
LOBL, MD, LAWRENCE T	ALLEGHENY
LOCKE, MD, DARRON B	BLAIR
LOCKE, MD, DAVID L	ALLEGHENY
LOCKE, MD, HARRY R	MONTGOMERY
LOCKEY III, MD, STEPHEN D	LANCASTER
LOCKWOOD, DO, KATHLEEN I	MONTOUR
LODER, DO, DONALD I	BERKS
LODISE, MD, RAYMOND J	PHILADELPHIA
LOEB, MD, ROBERT L	ERIE
LOEB, MD, ROLAND A	LANCASTER
LOEFFLER JR, MD, JOHN G	CUMBERLAND
LOEPER, MD, DONALD J	BERKS
LOEV, MD, MARVIN	BUCKS
LOFFREDA-MANCINELLI, MD, CLAUDIO	BEAVER
LOFTUS, MD, JOSEPH A	LUZERNE
LOFTUS, MD, THOMAS A	PHILADELPHIA
LOGAN, CAROLINE V	STUDENT
LOGAN, MD, KENNETH M	ALLEGHENY
LOGAN, MD, MARTHA L	PHILADELPHIA
LOGAN, MD, THOMAS M	PHILADELPHIA
LOGUE, MD, JAMES G	PHILADELPHIA
LOGUE III, MD, JAMES G	BERKS
LOH, MD, CHARLES K	CUMBERLAND
LOHIER, MD, RAYMOND	PHILADELPHIA
LOHIN, DO, DAVID L	LACKAWANNA
LOK, MD, MAI PAI	SCHUYLKILL
LOLLEY, MD, DAVID M	ALLEGHENY
LOMAGO, DEAN F	STUDENT
LOMAX JR, MD, WALTER P	PHILADELPHIA
LOMBARD, MD, MICHAEL F	LUZERNE
LOMBARD, MD, ROBERT M	LANCASTER
LOMBARDI, JOSEPH V	STUDENT
LOMBOY, MD, NORMA T	LEHIGH
LOMIS, MD, THOMAS J	YORK
LONDINO JR, MD, ALDO V	ALLEGHENY
LONDON, MD, GLADYS Z	DELAWARE
LONDON, MD, PHILIP	PHILADELPHIA
LONDON, MD, W THOMAS	PHILADELPHIA
LONG, MD, BRIAN K	WARREN
LONG, MD, DAVID A	DAUPHIN
LONG, MD, DAVID F	CHESTER
LONG, MD, J STEPHEN	YORK
LONG, MD, JOSEPH P	CUMBERLAND
LONG, MD, KATHLEEN B	MONTGOMERY
LONG, MD, RICHARD A	WASHINGTON
LONG, MD, RICHARD W	ERIE
LONG, MD, ROBERT D	UNION
LONG, MD, RONALD A	HUNTINGDON
LONG, MD, THEODORE K	LEBANON
LONG, TRICIA A	STUDENT
LONG JR, MD, HERBERT C	INDIANA
LONG JR, MD, JOHN C	DAUPHIN
LONG JR, MD, WILLIAM C	CLINTON
LONGACRE, MD, HELENE C	CHESTER
LONGACRE, MD, JANE M	MONTGOMERY
LONGARINI, MD, RICARDO	SCHUYLKILL
LONGENBACH, MD, ERIC W	LYCOMING
LONGENECKER, MD, BENJAMIN E	BERKS
LONGENECKER, MD, JOSEPH C	PHILADELPHIA
LONGENECKER, MD, ROGER N	BERKS
LONGENECKER, MD, STEPHEN C	BERKS
LONGENHAGEN, MD, JOHN B	LEHIGH
LONGNECKER, MD, DAVID E	PHILADELPHIA
LONGO, MD, SANTO	NORTHAMPTON
LONGO-MALLOY, DO, DEBORAH R	PHILADELPHIA
LONGSTREET, MD, PETER L	ERIE
LONGWELL, MD, ROBERT H	LANCASTER
LONGWELL JR, MD, BENTON E	CAMBRIA
LONSDORF, MD, RICHARD G	PHILADELPHIA
LOOMIS, MD, MARIO G	CHESTER
LOOSE, DO, GEORGE T	LEBANON
LOPATOFSKY, MD, DAVID J	LYCOMING
LOPEZ, MD, AGAPITO	LUZERNE
LOPEZ, MD, AISA G	PHILADELPHIA
LOPEZ, MD, KATHY S	ALLEGHENY
LOPEZ MONEGRO, MD, RAFAEL	MIFFLIN/JUNIATA
LOPEZ-WARREN, MD, YVETTE M	MONTGOMERY
LOPONTE, MD, MARIE A	PHILADELPHIA
LORBER, MD, STANLEY H	PHILADELPHIA
LORD, MD, KENNETH J	ERIE
LORD, MD, WILLIAM H	BERKS
LOREMAN, DO, LORIE	BUCKS
LORENZ III, MD, STEPHEN A	ALLEGHENY
LORENZO, MD, FREDERICK V	ADAMS
LORETAN, DO, WILLIAM D	LANCASTER
LORRAINE, MD, RICHARD S	MONTGOMERY
LOSKEN, MD, H WOLFGANG	ALLEGHENY

LOSS, DO, BETH A YORK
LOTHE, MD, PRADEEP A DELAWARE
LOTTICK, MD, EDWARD A LUZERNE
LOTZ, MD, ANDREW J CHESTER
LOUGH, MD, FREDERICK C BERKS
LOUGHLIN, DO, DONNA J MONTGOMERY
LOUGHMAN, MD, LINDA ALLEGHENY
LOUGHRAN, DO, DAVID H BUCKS
LOUIS-CHARLES, MD, ROY PHILADELPHIA
LOUTON, MD, FANNY X BLAIR
LOUTON, MD, ROBERT B BLAIR
LOUX, MD, NORMAN L BUCKS
LOVE, MD, CAROL A PHILADELPHIA
LOVE, MD, MICHAEL B PHILADELPHIA
LOVE, MD, WILLARD H DAUPHIN
LOVECCHIO, MD, FRANCIS A MONROE
LOVELACE, DO, NANCE A LUZERNE
LOVELL, MD, DONALD R BLAIR
LOVERANES, MD, MARIANO D ERIE
LOVETT, MD, GEORGE W ALLEGHENY
LOVETT, MD, WILLIAM J LEBANON
LOVETTE, MD, JOHN B CAMBRIA
LOVRINIC, MD, DANIEL F LUZERNE
LOVRINIC, MD, WILLIAM S CHESTER
LOWDEN, PATRICK M STUDENT
LOWDER JR, MD, RALPH J ALLEGHENY
LOWE, MD, DIANE A LUZERNE
LOWE, MD, STEPHEN J MONTGOMERY
LOWENGRUB, MD, KATHERINE M ALLEGHENY
LOWENSTEIN, MD, ADAM D PHILADELPHIA
LOWENSTEIN, MD, ROBERT A WASHINGTON
LOWERY, MD, WILLA D ALLEGHENY
LOWMAN, MD, GERALD F NORTHAMPTON
LOWRY, MD, DAVID W ALLEGHENY
LOWRY, MD, DON A CAMBRIA
LOWRY, MD, DONALD J DAUPHIN
LOWRY, MD, LOUIS D PHILADELPHIA
LOWY JR, MD, ALEXANDER D ALLEGHENY
LOZANO, MD, RAMON G ALLEGHENY
LU, MD, CALVIN CHESTER
LU, DONG T STUDENT
LU, MD, LUIS W ELK/CAMERON
LU, MD, MILTON M LANCASTER
LU, MD, RONG B PHILADELPHIA
LUBAHN, MD, JOHN D ERIE
LUBBE, MD, WILLEM J LYCOMING
LUBERTI, MD, ANTHONY A PHILADELPHIA
LUBIC, MD, LOWELL G ALLEGHENY
LUBIN, MD, EDWARD PHILADELPHIA
LUBIN, DO, HOWARD S DELAWARE
LUBIN, MD, JOSEPH D PHILADELPHIA
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LUBOW, MD, HARRY WESTMORELAND
LUCA, DO, MARYBETH LUZERNE
LUCAS, MD, DONNA M ALLEGHENY
LUCAS, MD, GLYNDA W DELAWARE
LUCAS, MD, R DUBOIS PHILADELPHIA
LUCAS, MD, RICHARD M LANCASTER
LUCAS, MD, TIMOTHY A STUDENT
LUCAS-FEHM, MD, LYNN MICHELE PHILADELPHIA
LUCENA, MD, ERNESTO E DELAWARE
LUCEY III, MD, DENIS J PHILADELPHIA
LUCHETTE, MD, ALBERT A MERCER
LUCID, MD, EMILY J ALLEGHENY
LUCIER, MD, ALFRED C DELAWARE
LUCINE JR, MD, ALBERT A CHESTER
LUCKENBAUGH, MD, AMY S YORK
LUDIVICO, MD, CHARLES L NORTHAMPTON
LUDKIEWICZ, MD, WAYNE S BEAVER
LUDMER, MD, MARIO ALLEGHENY
LUDOLPH, MD, CAROL ANN PHILADELPHIA
LUDWICK, MD, DAVID J BUCKS
LUDWICKI, MD, JOHN J MONTGOMERY
LUDWIG, MD, KARL D ALLEGHENY
LUDWIG, MD, KARLA M LEBANON
LUDWIG, MD, STEPHEN PHILADELPHIA
LUECKE, MD, GAIL A BERKS
LUELLEN, JOHN R STUDENT
LUFT, MD, WILLIAM C BRADFORD
LUGINBUHL, MD, WILLIAM E CHESTER
LUGUE, MD, CARMELA S CLEARFIELD
LUGUE JR, MD, AMADO B CLEARFIELD
LUK, JOHN C STUDENT
LUK, MD, STEPHEN S DAUPHIN
LUKACS, MD, KORNEL BLAIR
LUKAS, MD, RAYMOND A LYCOMING
LUKASZCZYK, MD, JOHN J NORTHAMPTON
LUKASZCZYK, MD, THOMAS A NORTHAMPTON
LUM, MICHAEL H STUDENT
LUMISH, MD, ROBERT M ALLEGHENY
LUNA, MD, FREDESVINDA CLEARFIELD
LUNA, MD, ROBERTO S CLEARFIELD
LUND, MARK E STUDENT
LUND, MD, PEERE C CAMBRIA
LUND, MD, PETER S ERIE
LUNDIE, MD, WILLIAM M WESTMORELAND
LUNDQUIST, MD, THOMAS G ALLEGHENY
LUNDY, MD, BARBARA S MONTGOMERY
LUNDY, MD, EDWARD F LANCASTER
LUNDY, MD, THEODORE PHILADELPHIA
LUNSFORD, MD, L DADE ALLEGHENY
LUO, MD, SOLOMON C SCHUYLKILL
LUONG, JIM K STUDENT
LUONGO JR, MD, ROMEO A PHILADELPHIA
LUPARELLO, MD, FRANK J ALLEGHENY
LUPARIELLO, MD, ANGELO D ALLEGHENY
LUPINACCI, MD, MICHAEL F DAUPHIN
LUPINETTI, MD, MICHAEL F ALLEGHENY
LURIE, MD, ABRAHAM A MONTGOMERY
LURIE, SHARI D STUDENT
LUSCH, MD, CHARLES J BERKS
LUSCOMBE, MD, HERBERT A PHILADELPHIA
LUSCOMBE, MD, HERBERT J BUCKS
LUSH, MD, DAVID T PHILADELPHIA
LUSSER, MD, MARTHA A LEHIGH
LUSTBADER, MD, MICHAEL L BEAVER
LUSTIG, MD, KEITH A ERIE
LUSTINE, MD, HOWARD T PHILADELPHIA
LUTES, DO, RONALD A WESTMORELAND
LUTHER, MD, ROBERT J CAMBRIA
LUTHRA, MD, DAMYANTI WESTMORELAND
LUTHRA, MD, MANMOHAN S WESTMORELAND
LUTINS, MD, JAY A ALLEGHENY
LUTNESS, MD, MARK P MONTOUR
LUTZ, MD, CHARLES K BERKS
LUTZ, MD, R BRUCE DELAWARE
LUTZ, MD, RAYMOND J LEHIGH
LUTZ, MD, RONALD A LEHIGH
LUTZ, MD, WENDY J STUDENT
LUTZ JR, MD, ROLAND B MONTGOMERY
LUTZ JR, RONALD A STUDENT
LWIN, MD, TINT ALLEGHENY
LYCHAK, MD, JOHN C NORTHAMPTON
LYET, MD, J PAUL LANCASTER
LYKENS, MD, HARRY D CENTRE
LYNAM, MD, EDWARD P ALLEGHENY
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LYNCH, MD, CHRISTOPHER G LEHIGH
LYNCH, MD, FRANK C LEBANON
LYNCH, MD, JAMES D BERKS
LYNCH, MD, JAMES J PHILADELPHIA
LYNCH, DO, WILLIAM J CLARION
LYND JR, MD, CLIFFORD W YORK
LYNDE, GRANT C STUDENT
LYNE, MD, JOHN C ALLEGHENY
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LYON-LOFTUS, MD, GREGORY T FRANKLIN
LYONS, MD, CHRISTINE W CHESTER
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LYONS, MD, WILBERT A BUCKS
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MACDONALD, MD, ROBERT R ALLEGHENY
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MACDOUGALL, MD, ROBERT D YORK
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MACHIRAJU, MD, V R ALLEGHENY
MACHT JR, MD, ELMER L PHILADELPHIA
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MACLEOD, MD, GORDON K ALLEGHENY
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MADDEN, MD, FRANCIS P BUCKS
MADDEN, MD, KEVIN G LACKAWANNA
MADDEN, MD, ROBERT A BUCKS
MADDEN, MD, STEPHANIE D DAUPHIN
MADDER, DO, ROBERT D BEAVER
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MADEWELL, MD, JOHN E DAUPHIN
MADHAVAN, MD, VASANTHA C ALLEGHENY
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MADOFF, MD, HENRY R ALLEGHENY
MADONNA, MD, DINO PHILADELPHIA
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MADOR, MD, ANNE T PHILADELPHIA
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MAENZA, MD, RONALD M PHILADELPHIA
MAERZ, MD, JOHN C MONTGOMERY
MAFFEO, MD, ALPHONSE A LEHIGH
MAGALSKI JR, JOSEPH J STUDENT
MAGARGAL, MD, HELGA O PHILADELPHIA
MAGARGAL, MD, LARRY E PHILADELPHIA
MAGARGEE, DO, SUSAN P DELAWARE
MAGARGLE, MD, R LYNN DAUPHIN
MAGBOJOS, MD, QUIRICO R FRANKLIN
MAGBOJOS, MD, ZENAIDA V FRANKLIN
MAGEE, MD, JOAN M CHESTER
MAGEE, MD, JOHN G PHILADELPHIA
MAGEE, MD, MICHAEL C PHILADELPHIA
MAGEE, MD, RICHARD S BLAIR
MAGGITTI, MD, MICHAEL J CHESTER
MAGID, MD, D RIVA MONTGOMERY
MAGID, MD, WARREN P YORK
MAGIDENKO, MD, LEONID LUZERNE
MAGILL, MD, WILLIAM H PERRY
MAGILL III, MD, JOHN T UNION
MAGILNER, MD, ARTHUR D PHILADELPHIA
MAGILNER, MD, LOUIS PHILADELPHIA
MAGILNER, MARK STUDENT
MAGLEY, MD, ROBERT S CAMBRIA
MAGNESS, MD, KATHLEEN E CHESTER
MAGNIFICO, DO, BETH A DAUPHIN
MAGNUSSON, MD, MARK R PHILADELPHIA
MAGOON, MD, SHEILA M BRADFORD
MAGOUN, MD, GEORGE L ERIE
MAGOVERN, MD, GEORGE J ALLEGHENY
MAGOVERN, MD, JAMES A ALLEGHENY
MAGOVERN JR, MD, GEORGE J ALLEGHENY
MAGRAN, MD, LEONARDO PHILADELPHIA
MAGUIRE, MD, ALBERT M PHILADELPHIA
MAGUIRE, MD, DAVID P PHILADELPHIA
MAGUIRE, DO, F WILLIAM CHESTER
MAGUIRE, MD, JOSEPH I DELAWARE
MAGUIRE, MD, JOSEPH I DELAWARE
MAGUIRE, MD, LEO J DELAWARE
MAGUIRE, PATRICK D STUDENT
MAHAJAN, MD, ANAND B LANCASTER
MAHALINGAPPA, MD, C WESTMORELAND
MAHAN, MD, JAMES C ALLEGHENY
MAHAN, MD, JOHN P BUCKS
MAHARAJH, MD, BALKISSOON A CAMBRIA
MAHBOUBI, MD, SOROOSH PHILADELPHIA
MAHER, MD, JENNIFER A BEAVER
MAHER, MD, JOHN C ALLEGHENY
MAHER, MD, JOHN P CHESTER
MAHER, MD, REGIS M FAYETTE
MAHER, MD, YVONNE B ALLEGHENY
MAHER JR, MD, THOMAS D ALLEGHENY
MAHIDHARA, MD, SESHU ALLEGHENY
MAHMOOD, MD, ARSHAD ALLEGHENY
MAHMOOD, MD, EDNA Z BERKS
MAHMUD, MD, FARUQ MONTOUR
MAHMUD, MD, RASHIDA P ALLEGHENY
MAHON, MD, MARILYN S DAUPHIN
MAHON, MD, WILMER B DAUPHIN
MAHONEY, EXEC DIR, BONITA C LYCOMING
MAHONY, MD, ELLEN A MONTGOMERY
MAHOOD, MD, WILLIAM H MONTGOMERY
MAHSOOB, MD, ABDUL HAMED ALLEGHENY
MAIDA, MD, FRANK V WESTMORELAND
MAIDANSKY, MD, IGOR BERKS
MAIDEN, MD, PHILLIP G MERCER
MAIER, MD, WILLIS P PHILADELPHIA
MAIGUR, MD, WILLIAM S LACKAWANNA
MAILHOT, MARK F STUDENT
MAILMAN, MD, WENDY R UNION
MAINGI, MD, NARESH S DAUPHIN
MAINZER, MD, FRANCIS K ERIE
MAIORANA, MD, S LEROY BERKS
MAISEL, MD, WILFRED NORTHAMPTON
MAISH JR, MD, GEORGE O NORTHAMPTON
MAISSEL, MD, GERDA S PHILADELPHIA
MAISTROW, MD, MARLA G PHILADELPHIA
MAITIN, MD, ELLEN C PHILADELPHIA
MAITLAND, MD, LEAH A ADAMS
MAITRA, MD, SUBHASHIS BLAIR
MAJCHRZAK JR, MD, CHARLES G BRADFORD
MAJDAN, MD, JOSEPH F PHILADELPHIA
MAJDIC, DO, JAMES P LUZERNE
MAJERNICK, DO, THOMAS G WYOMING
MAJMUDAR, MD, PARAG A ALLEGHENY
MAJMUDAR, MD, VASANTI H ALLEGHENY
MAJOR, MD, DAVID A PHILADELPHIA
MAKAROWSKI, MD, WILLIAM S ERIE
MAKARY, MD, ADEL Z MONTOUR
MAKDAD, MD, AMEENE G WESTMORELAND
MAKHDOMI, MD, A RASHID NORTHAMPTON
MAKHIJA, MD, KAILASH R CARBON
MAKLER, MD, JACOB S PHILADELPHIA
MAKLER JR, MD, P TODD PHILADELPHIA
MAKOUS, MD, NORMAN PHILADELPHIA
MAKSIMAK, MD, MARTIN MONTOUR
MALACARI, MD, DOMINIC V LUZERNE
MALACOFF, MD, ROBERT F NORTHAMPTON
MALAMUT, MD, RICHARD I DELAWARE
MALAY, MD, MARY BETH STUDENT
MALAYIL, MD, MICHAEL T WASHINGTON
MALCOLM, MD, DONALD C HUNTINGDON
MALCOLM JR, MD, JOHN A UNION
MALCOM, MD, RONALD H YORK
MALEK, MD, MANSOUR PHILADELPHIA
MALEPATI, MD, VASU GREENE
MALETA, VIVIANA M STUDENT
MALEY, MD, EDWARD D LANCASTER
MALEY, MD, RICHARD H ALLEGHENY
MALHOTRA, MD, NARINDER K ALLEGHENY
MALHOTRA, MD, RAJESHWAR P MIFFLIN/JUNIATA
MALHOTRA, MD, RITU PHILADELPHIA
MALHOTRA, MD, SHASHPAL MIFFLIN/JUNIATA
MALICK, MD, ALNOOR A BRADFORD
MALICK, MD, DONALD V SCHUYLKILL
MALICK, MD, GERALD P BERKS
MALICKI, MARK M STUDENT
MALIK, MD, DURDANA A DELAWARE
MALIK, MD, HUSSAIN G MONROE
MALIK, MD, KHALID M ARMSTRONG
MALIK, MD, MAQSOOD A SCHUYLKILL
MALIK, MD, RAJAT P JEFFERSON
MALIN, MD, THOMAS H DAUPHIN
MALINER, MD, LLOYD I DAUPHIN
MALINIAK, MD, KEITH K DAUPHIN
MALINOWSKI, MD, JOHN A ALLEGHENY
MALISHAUCKI, MD, MARY G SCHUYLKILL
MALIT, MD, FIORELLO G ALLEGHENY
MALIT, MD, LEE A MONTGOMERY
MALIT, MD, PAULITA Y ALLEGHENY
MALIVER, MD, DEBORAH S INDIANA
MALIVER, MD, LEONARD E INDIANA
MALJOVEC, MD, JOSEPH J WARREN
MALKIN, MD, ALAN G PHILADELPHIA
MALKIN, MD, RICHARD L PHILADELPHIA
MALKOWICZ, MD, STANLEY B PHILADELPHIA
MALL, MD, ALBERT K CAMBRIA
MALLER, MD, ERIC S PHILADELPHIA
MALLER, MD, JACALYN S PHILADELPHIA
MALLINGER, MD, MARK L ALLEGHENY
MALLINGER, MD, MICHAEL ALLEGHENY
MALLINGER, MD, SAMUEL H BEAVER
MALLOTT, MD, I FLOYD ALLEGHENY
MALLOY, MD, EDWARD L ALLEGHENY
MALLOY, MD, EDWIN S LACKAWANNA
MALLOY, MD, TERRENCE R PHILADELPHIA
MALMUD, MD, LEON S PHILADELPHIA
MALOLES JR, MD, ORLANDO Z DELAWARE
MALONE, JAMES P STUDENT
MALONE, MD, MARK S ALLEGHENY
MALONEY, MD, DONALD W MONTGOMERY
MALONEY, MD, RICHARD W ERIE
MALPANI, MD, AJAY R DAUPHIN
MALTA, DO, RAYMOND J BUCKS
MALVAR, MD, THOMAS Q LAWRENCE
MAMA, MD, SAIFUDDIN T PHILADELPHIA
MAMBU, MD, JOSEPH F MONTGOMERY
MAMROS, MD, MARK A WASHINGTON
MAMULA, MD, MILTON ALLEGHENY
MANASSE, MD, HOWARD S ERIE
MANAYAN, DO, CONRAD C MERCER
MANCANO, MD, LOUIS D MONTGOMERY
MANCANO, MD, MARYANN P BERKS
MANCHESTER, MD, GEORGE A LYCOMING
MANCIA, MD, BONITA M LUZERNE
MANCINI, MD, ALFRED M ALLEGHENY
MANCINI, SHERI A STUDENT
MANCINO, MD, PETER J LAWRENCE
MANDAL, MD, SANAT K PHILADELPHIA
MANDALAKAS, MD, NICHOLAS J LANCASTER
MANDARINO, MD, MICHAEL J PHILADELPHIA
MANDAVA, MD, SRINIVAS DAUPHIN
MANDEL, MD, JEFFREY M PHILADELPHIA
MANDEL, MD, MARTIN M PHILADELPHIA
MANDEL, MD, ROBERT J DAUPHIN
MANDEL, MD, STEVEN PHILADELPHIA
MANDELKORN, MD, ROBERT M ALLEGHENY
MANDELL, MD, MORTON S PHILADELPHIA
MANDERS, MD, ERNEST K DAUPHIN
MANDETTA, MD, DONALD F CENTRE
MANDLER, MD, JOHN I MONTGOMERY
MANFREY, DO, FRANK J MONTGOMERY
MANFREY, DO, SAMUEL J MONTGOMERY
MANGANARO, MD, KIMBERLY J MIFFLIN/JUNIATA
MANGANIELLO, MD, CHARLES M LUZERNE
MANGELS, MD, DAVID G ALLEGHENY
MANGES, MD, JOHN P FRANKLIN
MANGIONE, MD, MICHAEL P ALLEGHENY
MANHOFF, MD, DION T PHILADELPHIA
MANI, MD, SHOBHA T PHILADELPHIA
MANIGLIA, MD, ANTHONY J BLAIR
MANIGLIA, MD, RICHARD J MONTGOMERY
MANIGLIA, MD, ROSARIO DAUPHIN
MANIN, MD, GORDON C DELAWARE
MANJON, MD, JOSE M DAUPHIN
MANKO, MD, MICHAEL A MONTGOMERY
MANKOVICH, MD, PAUL A WESTMORELAND
MANLEY, MD, DONELSON R PHILADELPHIA
MANLOVE, MD, FRANCIS R PHILADELPHIA
MANN, MD, BARRY D PHILADELPHIA
MANN, MD, DOUGLAS G DELAWARE
MANN, MD, IRVING A DELAWARE
MANN, MD, RICHARD M ALLEGHENY
MANN, MD, ROBERT J MONTGOMERY

MANN, RONALD M	STUDENT
MANN JR, MD, DAVID E	YORK
MANNARINO, MD, ANTHONY P	BUCKS
MANNELLA, MD, JOSEPH J	ALLEGHENY
MANNELLA, MD, WILLIAM J	DELAWARE
MANNES, MD, ANDREW J	PHILADELPHIA
MANNESS, MD, WAYNE K	PHILADELPHIA
MANNHEIMER, ALAN L	STUDENT
MANNING, MD, ANNE M	DAUPHIN
MANNING, DO, CATHY J	YORK
MANNING, MD, DENNIS M	ALLEGHENY
MANNING, MD, HARRY L	LYCOMING
MANNING, MD, JAMES A	YORK
MANNING, MD, JAMES A	ALLEGHENY
MANNING, MD, RICHARD G	DAUPHIN
MANNING, MD, RUSSELL G	JEFFERSON
MANNINO, MD, STANLEY C	ALLEGHENY
MANNION, MD, JOHN D	PHILADELPHIA
MANNISI, MD, JOHN A	NORTHAMPTON
MANNO, MD, CATHERINE S	PHILADELPHIA
MANNO JR, MD, BRUNO V	PHILADELPHIA
MANOLUKAS, DO, PETER G	BEAVER
MANRIQUE, MD, JOSE V	LUZERNE
MANSELL, MD, JOHN L	LAWRENCE
MANSFIELD, MD, CARL M	PHILADELPHIA
MANSFIELD, MD, RICHARD J	CHESTER
MANSOUR, MD, GEORGE E	LEHIGH
MANSTEIN, MD, CARL H	PHILADELPHIA
MANSTEIN, MD, GEORGE	PHILADELPHIA
MANSTEIN, MD, MARK E	PHILADELPHIA
MANSURE, MD, FRANK T	DELAWARE
MANTIA, MD, AUGUST M	ALLEGHENY
MANTICA, MD, ROBERT P	BEAVER
MANTING-BREWER, MD, MICHELE A	CENTRE
MANUBAY, MD, JOHN A	YORK
MANUBAY, MD, MARCELO A	BERKS
MANUEL, MD, LAUREANO M	COLUMBIA
MANUEL, MD, MARISTELA M	PHILADELPHIA
MANUELL, MD, MARY-ELISE	PHILADELPHIA
MANUS, MD, NATHAN	PHILADELPHIA
MANZELLA, MD, EDWARD D	CARBON
MANZELLA, MD, JOHN P	YORK
MANZETTI, MD, GENE W	ALLEGHENY
MANZIONE, MD, MARC	MONTGOMERY
MANZO, MD, THOMAS L	MONTGOMERY
MAQUERA, MD, ANDRE G	LEHIGH
MARAKOWSKI, DO, JAMES J	PERRY
MARAR, MD, ISAM E	ALLEGHENY
MARASCO JR, MD, JOSEPH A	ALLEGHENY
MARATTA, MD, JAN W	ALLEGHENY
MARAVALLI, MD, CAMILLE J	CAMBRIA
MARAZZO, MD, DONALD P	ALLEGHENY
MARBACH, MD, A HERBERT	PHILADELPHIA
MARBAN, MD, ALEX J	PHILADELPHIA
MARCELIS, MD, JOHN F	PHILADELPHIA
MARCELLA, MD, LAWRENCE C	LAWRENCE
MARCELLA, MD, STEPHEN W	LUZERNE
MARCELO, MD, FLORDELIZA S	PHILADELPHIA
MARCH, MD, HERMAN C	MONTGOMERY
MARCH, THERESA M	STUDENT
MARCHANT, MD, ERIC A	BUCKS
MARCHANT, MD, LEWIS K	PHILADELPHIA
MARCHETTO, MD, PAUL A	PHILADELPHIA
MARCHINSKI, MD, LEONARD J	BERKS
MARCIANO, MD, JULIET A	BUCKS
MARCINCIN, MD, PAUL G	NORTHAMPTON
MARCINCIN, MD, ROBERT P	NORTHAMPTON
MARCINIK, DO, MARGARET E	MONTOUR
MARCONIS, MD, JOSEPH T	SCHUYLKILL
MARCOTTE, MD, PAUL J	PHILADELPHIA
MARCOUX, MD, ANNE-MARIE C	BUCKS
MARCUCCI, MD, JAMES W	ALLEGHENY
MARCUCCI, MD, MICHAEL C	PHILADELPHIA
MARCUS, MD, DONALD J	CHESTER
MARCUS, MD, DONALD K	PHILADELPHIA
MARCUS, MD, GARY J	BEAVER
MARCUS, MD, JEROME I	BERKS
MARCUS, MD, JOHN W	FAYETTE
MARCUS, MD, MICHAEL S	PHILADELPHIA
MARCY, MD, JOSEPH H	ALLEGHENY
MARCZYK, MD, STANLEY C	DELAWARE
MARDAYAT, MD, MAULANA	BEDFORD
MARDEN, MD, PHILIP A	PHILADELPHIA
MARFATIA, MD, SUDHIR K	BUCKS
MARFATIA, MD, USHA S	BUCKS
MARGARIDA, MD, LEOPOLDO E	MONTGOMERY
MARGATE, MD, PEDRO R	PHILADELPHIA
MARGERUM, MD, BRYAN S	STUDENT
MARGIE JR, MD, WALTER E	NORTHAMPTON
MARGOLES, MD, LOUIS	PHILADELPHIA
MARGOLIN, MD, JUDITH F	PHILADELPHIA
MARGOLIS, MD, BERNARD	PHILADELPHIA
MARGOLIS, MD, BERNARD M	DAUPHIN
MARGOLIS, MD, HARRY M	ALLEGHENY
MARGOLIS, MD, STEPHEN H	PHILADELPHIA
MARGUGLIO, DO, A EUGENE	CLARION
MARI-MAYANS, MD, JUAN B	WESTMORELAND
MARIANI, MD, STEPHEN S	LACKAWANNA
MARIANO JR, MD, BENEDICTO P	WESTMORELAND
MARIANO JR, MD, TOMAS A	LYCOMING
MARIGLIO, MD, JOSEPH A	BERKS
MARINARI, MD, LAWRENCE A	MONTGOMERY
MARINARO, MARIA	STUDENT
MARINELLI, MD, RICCARDO R	ALLEGHENY
MARINO, ALLEN T	STUDENT
MARINO, MD, DANIEL J	DELAWARE
MARINO, MD, GLEN A	SCHUYLKILL
MARINO, MD, JOSEPH N	LACKAWANNA
MARINO, LOUIS C	STUDENT
MARINO, MD, RALPH	PHILADELPHIA
MARINO, DO, THOMAS N	CHESTER
MARINO JR, MD, LOUIS J	ALLEGHENY
MARINSTEIN, MD, RHEA A	ALLEGHENY
MARION, MD, DONALD W	ALLEGHENY
MARION, MD, ROY H	BEAVER
MARIOTTI, MD, RITA A	BUCKS
MARK, MD, GEORGE E	PHILADELPHIA
MARK, MD, WILLIAM S	CHESTER
MARKARIAN, MD, MICHAEL	SUSQUEHANNA
MARKAS, MD, MICHAEL S	ALLEGHENY
MARKIEWICZ, MD, ANN M	DAUPHIN
MARKLEY, MD, RALPH	LAWRENCE
MARKMANN, MD, WILLIAM J	PHILADELPHIA
MARKOFF, MD, JOSEPH I	PHILADELPHIA
MARKOS, MD, RONALD P	BUCKS
MARKOW, MD, HARRY G	BUCKS
MARKOWITZ, MD, HANK E	LAWRENCE
MARKOWITZ, MD, RICHARD I	PHILADELPHIA
MARKOWSKI, MD, WILLIAM J	PHILADELPHIA
MARKS, MD, DAVID I	PHILADELPHIA
MARKS, MD, GERALD	PHILADELPHIA
MARKS, MD, MEYER A	PHILADELPHIA
MARKS, MD, STANLEY M	ALLEGHENY
MARKS, MD, VICTOR J	MONTOUR
MARKS TABBY, MD, SARA	PHILADELPHIA
MARKSON, MD, VICTOR I	BEAVER
MARKSON, MD, WILLIAM M	CARBON
MARLAPUDI, MD, PREM K	BUCKS
MARLOWE, MD, FRANK I	PHILADELPHIA
MARLOWE, MD, SCOTT D	ALLEGHENY
MARMAR, MD, EARL C	PHILADELPHIA
MARMO, MD, THEODORE	LACKAWANNA
MARNATTI, MD, CARL T	ALLEGHENY
MARON, MD, JOHN J	MONTGOMERY
MARON, MD, NORMAN L	NORTHAMPTON
MARONE, MD, PHILLIP J	PHILADELPHIA
MAROON, MD, JOSEPH C	ALLEGHENY
MAROON, MD, MICHELE S	MONTOUR
MAROON, MD, THOMAS J	WESTMORELAND
MAROPIS, MD, CHRISTOPHER G	ALLEGHENY
MAROUS III, MD, JOSEPH J	ALLEGHENY
MARQUETAND, MD, RALPH A	STUDENT
MARQUEZ, MD, PEDRO A	FAYETTE
MARQUIS, MARIAN K	STUDENT
MARR, BRIAN P	STUDENT
MARRANGONI, MD, ALBERT G	ALLEGHENY
MARREN, AMY S	STUDENT
MARRERO, MD, CARLOS J	WESTMORELAND
MARRERO, MD, LUIS B	MCKEAN
MARRONE, MD, GARY C	ALLEGHENY
MARRONE, MD, MICHAEL S	LEBANON
MARRYSHOW, MD, BASIL A	ALLEGHENY
MARSCHNER JR, MD, RICHARD K	DAUPHIN
MARSH, MD, CAROL L	CHESTER
MARSHALL, MD, DAVID S	SCHUYLKILL
MARSHALL, MD, E WAYNE	PHILADELPHIA
MARSHALL, MD, HELEN L	SCHUYLKILL
MARSHALL, MD, JACK H	ERIE
MARSHALL, MD, JANE M	VENANGO
MARSHALL, MD, JOHN E	BERKS
MARSHALL, MD, JOHN S	BEAVER
MARSHALL, DO, LONNIE L	ALLEGHENY
MARSHALL, RENEE L	STUDENT
MARSHALL, DO, SHEILA F	BEAVER
MARSHALL, MD, WAYNE K	DAUPHIN
MARSHALL, MD, WILLIAM C	ALLEGHENY
MARSHALL JR, MD, MATTHEW	ALLEGHENY
MARSILI, MD, MARK A	LACKAWANNA
MARTE, MD, EGON	DAUPHIN
MARTE, MD, JORGE G	PHILADELPHIA
MARTELL JR, MD, JOHN R	ALLEGHENY
MARTENS, MD, JEFFREY D	ALLEGHENY
MARTHOUSE, MD, STEPHEN J	MIFFLIN/JUNIATA
MARTIDIS, ADAM	STUDENT
MARTIN, MD, C EDWIN	YORK
MARTIN, MD, CHERYL A	BUCKS
MARTIN, MD, CLARENCE H	PHILADELPHIA
MARTIN, MD, DAVID C	WESTMORELAND
MARTIN, MD, DONALD E	LEBANON
MARTIN, MD, EDWARD T	PHILADELPHIA
MARTIN, DO, ELVIN L	SOMERSET
MARTIN, MD, ENRICO L	NORTHAMPTON
MARTIN, MD, FREDERICK H	LEHIGH
MARTIN, MD, FREDRIC W	ALLEGHENY
MARTIN, MD, GERALD B	CUMBERLAND
MARTIN, MD, H FRED	ADAMS
MARTIN, MD, J CAMPBELL	COLUMBIA
MARTIN, MD, J SCOTT	MONTOUR
MARTIN, JAMES D	STUDENT
MARTIN, MD, JAMES W	ALLEGHENY
MARTIN, MD, JAMES W	CRAWFORD
MARTIN, MD, JEFFREY A	WAYNE/PIKE
MARTIN, MD, JOHN H	MONTGOMERY
MARTIN, DO, LAURA M	LUZERNE
MARTIN, MD, MANUEL T	ALLEGHENY
MARTIN, MD, MARTINA M	MONTGOMERY
MARTIN, MD, MARYANNE	BLAIR
MARTIN, MD, MELANIE C	MONTGOMERY
MARTIN, MD, NANCY J	LANCASTER
MARTIN, MD, RICHARD A	LACKAWANNA
MARTIN, MD, RONALD C	CRAWFORD
MARTIN, MD, THOMAS J	ALLEGHENY
MARTIN, MD, THOMAS J	MONTOUR
MARTIN JR, MD, JOHN A	BERKS
MARTIN JR, MD, JOHN B	WASHINGTON
MARTINA, DO, PETER A	WASHINGTON
MARTINEK, GREGORY S	STUDENT
MARTINELLI, MD, JOSEPH A	ALLEGHENY
MARTINEZ, MD, AUGUSTO J	ALLEGHENY
MARTINEZ, MD, IRISAIDA	PHILADELPHIA
MARTINEZ, MD, JESS M	WASHINGTON
MARTINEZ, MD, JORGE A	ALLEGHENY
MARTINEZ, MANUEL A	STUDENT
MARTINEZ, MICHAEL F	STUDENT
MARTINEZ, MD, ZEFERINO	BERKS
MARTINEZ-RAMOS, MD, MARIA A	LEHIGH
MARTINI, MD, ENRICO E	LANCASTER
MARTINI, MD, MARY C	ALLEGHENY
MARTINI, MD, VICTOR S	ERIE
MARTINIE, JOHN B	STUDENT
MARTINSON, MD, MARK W	MONTOUR
MARTONE, MD, CHRISTINE	ALLEGHENY
MARTONE, MD, LOUIS H	ALLEGHENY
MARTSOLF, MD, JOHN	BEAVER
MARTSOLF, MD, ROBERT H	MERCER
MARTUCCI, MD, JOHN J	MONROE
MARTYAK, MD, NICHOLAS A	LUZERNE
MARTYN, MD, LOIS J	PHILADELPHIA
MARTYNEC, MD, BOHDAN	BUCKS
MARTYNOWICZ, DO, TED E	DELAWARE
MARTZ, MD, MARK N	LEHIGH
MARUNOWSKA, MD, ARLETTA U	ALLEGHENY
MARVA, MD, DONALD J	PHILADELPHIA
MARVEL, MD, RICHARD P	PHILADELPHIA
MARVI, MD, DAVOUD	LEHIGH
MARVIN, MD, ROBERT F	DELAWARE
MARWAHA, MD, ASHA	BUTLER
MARX, MD, DAVID G	MONTOUR
MARX, MD, MARVIN H	MONTGOMERY
MARYMOR, MD, NEIL S	MONTGOMERY
MARYNIAK, MD, GIRARD M	BERKS
MARZIANO, MD, MICHELE L	DELAWARE
MASANKAY, MD, MANUEL G	LACKAWANNA
MASCARENHAS, MD, DANIEL A N	NORTHAMPTON
MASCARENHAS, MD, MARIA R	PHILADELPHIA
MASCHKE, MD, STUART P	YORK
MASCIOTRA, MD, NICHOLAS J	CAMBRIA
MASH, MD, MICHAEL J	MONTGOMERY
MASIN, MD, F NED	ALLEGHENY
MASKARINEC, DO, BRUCE K	WASHINGTON
MASKOWITZ, MD, MARC	ALLEGHENY
MASLAND, MD, DAVID S	CUMBERLAND
MASLOFF, MD, MELVIN L	PHILADELPHIA
MASLOV, MD, MARC D	VENANGO
MASON, MD, CYNTHIA B	MONTGOMERY
MASON, MD, DANIEL	PHILADELPHIA
MASON, MD, GREGG C	ERIE
MASS, MD, KAREN J	ALLEGHENY
MASS, MD, SHARON B	PHILADELPHIA
MASSARI, MD, FERDINAND E	MONTGOMERY
MASSELLA, MD, ELIZABETH L	ALLEGHENY
MASSENGALE, MD, ALEXANDER T	BERKS
MASSEY, MD, GORDON J	ERIE
MASSIE, MD, MITCHELL T	ALLEGHENY
MASSOUD, MD, SAMUEL M	CAMBRIA
MASSUCCI, MD, JAMES E	ALLEGHENY
MAST, MD, TRUMAN E	LANCASTER
MASTANDREA, MD, CARL A	ALLEGHENY
MASTER, WILLIAM E	STUDENT
MASTERS, MD, RAYMOND E	ALLEGHENY
MASTERS, MD, RUTH S	ALLEGHENY
MASTERS, DO, THOMAS R	ERIE
MASTERSON, DO, JAMES N	WESTMORELAND
MASTRIAN, MD, ANTHONY S	LAWRENCE
MASTRINE, MD, LARRY R	CAMBRIA
MASUCCI, MD, DOUGLAS J	YORK
MATARESE, MD, EMIL L	BUCKS
MATASY, MD, VICTORIA L	ALLEGHENY
MATEER, MD, FRANK	ALLEGHENY
MATEER JR, MD, HARRY O	SCHUYLKILL
MATEO, MD, MICHAEL G	MONTGOMERY
MATEYA, MD, DENNIS J	ALLEGHENY
MATGOURANIS, MD, PETER M	BLAIR
MATHAI, MD, JOHN	YORK
MATHEO, MD, LORETA M	ALLEGHENY
MATHER, MD, PAUL J	MONTGOMERY
MATHEW, MD, ANNA	ALLEGHENY
MATHEWS, DO, JAMES C	BUTLER
MATHEWS, MD, ROBERT A	PHILADELPHIA
MATHEWS, MD, ROBERT S	LANCASTER
MATHEWS JR, MD, NEILSON M	MONTGOMERY
MATHIS, MD, JAMES G	BERKS
MATHIS, MD, JERRY L	BLAIR
MATHOS, DO, THOR C	ALLEGHENY
MATHUR, MD, AJAY K	ALLEGHENY
MATHUR, MD, DINESH P	CAMBRIA
MATHUR, MD, GEETA V	PHILADELPHIA
MATHUR, MD, KAILASH	SCHUYLKILL
MATITYAHU, AMIR M	STUDENT
MATLACK, MD, EILEEN O	BUCKS
MATLIN, DO, EMILY W	DAUPHIN
MATSKO, MD, JANE R	BERKS
MATSKO, MD, JANINE A	PHILADELPHIA
MATSKO, MD, MICHAEL E	LUZERNE
MATSKO, DO, ROBERT P	PERRY
MATSON, DO, BART L	NORTHAMPTON
MATSUMOTO, MD, TERUO	PHILADELPHIA
MATSUMURA, DAVID N	STUDENT
MATTA, DO, ROBERT A	LEHIGH
MATTA, MD, SHOUKRY	LAWRENCE
MATTA, DO, SUSAN S	LEHIGH
MATTEI, MD, DENNIS M	LACKAWANNA
MATTEI, MD, FRANK A	PHILADELPHIA
MATTEUCCI, MD, WALTER V	PHILADELPHIA
MATTHEWS, MD, GEORGE R	BERKS
MATTHEWS, MD, JOHN T	ALLEGHENY
MATTHEWS, MD, WARREN B	MONTGOMERY
MATTHEWS JR, MD, TED A	WESTMORELAND
MATTHEWS-MLAKAR, DO, MICHELE R	ALLEGHENY
MATTHYS-OLLODART, MD, SUSANNE E	PHILADELPHIA
MATTLEMAN, DO, JOEL H	LANCASTER
MATTLEMAN, MD, STEVEN J	PHILADELPHIA
MATTONE-VOLPE, MD, FRANCESCA	DELAWARE
MATTSON, MD, RONALD J	MONTGOMERY
MATTU, MD, AMAL	PHILADELPHIA
MATULEWICZ, MD, THEODORE J	LEHIGH
MATULEWSKI, MD, THOMAS J	DELAWARE
MATUNIS, MD, JOSEPH J	PERRY
MATUS, MD, NANCY R	NORTHAMPTON
MATZ, MD, KAREN M	MONTGOMERY
MAUE, MD, FREDERICK R	ALLEGHENY
MAUK, MD, JOYCE E	PHILADELPHIA
MAURER, MD, CAROL N	VENANGO
MAURER, MD, PHILIP M	PHILADELPHIA
MAURIELLO, DO, CHARLES A	PHILADELPHIA
MAUS, MD, MARLON T	PHILADELPHIA
MAUST, MD, PAUL E	BUTLER
MAUTHE, MD, ROBERT W	NORTHAMPTON
MAX, MD, MARTIN H	CAMBRIA
MAXA JR, DO, ROBERT L	ERIE
MAXIAN, DO, JOSEPH A	BUCKS
MAXIN, MD, CHARLES W	CENTRE
MAXSON JR, MD, CHESTER J	PHILADELPHIA
MAXWELL, MD, BETH A	WESTMORELAND
MAXWELL, MD, DORIS B	WESTMORELAND
MAXWELL, MD, EMILIE L	MONTGOMERY
MAXWELL, KRISTINE	STUDENT
MAXWELL, DO, STEVEN J	MONROE
MAXWELL JR, MD, HENRY L	ADAMS
MAXWELL JR, MD, ROBERT A	MONTGOMERY
MAY, MD, JOHN C	LANCASTER
MAY, MD, ROBERT E	PHILADELPHIA
MAY JR, MD, CARL J	YORK
MAY JR, MD, KENNETH J	DAUPHIN
MAYBERRY, DO, JOSEPH J	LANCASTER
MAYDONOVITCH, DO, DANIEL J	MONTGOMERY
MAYER, MD, DAVID P	PHILADELPHIA
MAYER, MD, HENRY S	MONTGOMERY
MAYER, MD, NATHANIEL H	PHILADELPHIA
MAYERNIK, MD, CURTIS V	ALLEGHENY
MAYERS JR, MD, STANLEY P	CENTRE
MAYLOCK, MD, JOHN H	BEDFORD
MAYLOCK, MD, JOHN V	MONTOUR
MAYNARD JR, MD, EUGENE H	WASHINGTON
MAYO, MD, EDITH A	DELAWARE
MAYOCK, MD, ROBERT L	PHILADELPHIA
MAYRO, MD, JULIAN	PHILADELPHIA
MAYS, WARREN L	STUDENT
MAZAHERI, MD, AHMED	BUCKS
MAZDA, DO, RUSSELL F	LANCASTER
MAZDISNIAN, FARHAD	STUDENT
MAZER, MD, HOWARD	PHILADELPHIA
MAZERO, MD, JOHN R	WESTMORELAND
MAZICH, MD, THERESA E	BUCKS
MAZLIN, MD, STEVEN E	BUCKS
MAZUZ, MD, MEIR	BERKS
MAZZA, MD, JOSEPH L	ALLEGHENY
MAZZA, MD, PATRICK A	BERKS
MAZZEI, MD, JOSEPH M	ALLEGHENY
MC ADAMS, MD, ANDREW J	ALLEGHENY
MC AFOOS, MD, GARY L	WARREN
MC AFOOS, MD, J ALLEN	ALLEGHENY
MC ALEER, MD, DAVID J	DELAWARE
MC ALLISTER, MD, HELEN B	PHILADELPHIA
MC ALLISTER, MD, JOHN D	ALLEGHENY
MC ALLISTER, MD, JOSEPH C	MONTGOMERY
MC ALLISTER, MD, MEADA J	DAUPHIN
MC ALLISTER, MD, NOREEN M	ALLEGHENY
MC ANDREW, MD, JOHN J	LACKAWANNA
MC ANDREW, DO, PATRICK J	LACKAWANNA
MC ARDLE, MD, GILBERT C	ADAMS
MC ARDLE, MD, M JACQUELYN	ADAMS
MC AULIFFE, MD, THOMAS C	PHILADELPHIA
MC AVOY, MD, WILLIAM B	ALLEGHENY
MC BEE, MD, ALDEN G	WASHINGTON
MC BETH JR, MD, ORVILLE G	ADAMS
MC BREARTY, MD, FRANCIS X	DELAWARE
MC BRIDE, MD, ANNE K	ALLEGHENY
MC BRIDE, DAVID R	STUDENT
MC BRIDE, MD, JAMES G	NORTHAMPTON
MC BRIDE, MD, THOMAS J	DELAWARE
MC BRYAN JR, MD, DONALD J	STUDENT
MC CABE, MD, JAMES L	MONTGOMERY
MC CABE, MD, JOHN S	WASHINGTON
MC CADDEN, MD, JOSEPH A	DELAWARE
MC CAFFERTY, MD, JOHN M	PHILADELPHIA
MC CAFFERTY, MD, JOHN P	PHILADELPHIA
MC CAFFERTY, MD, LEO R	ALLEGHENY
MC CAFFERTY, MD, MICHAEL H	ALLEGHENY
MC CAGUE, MD, NED J	ALLEGHENY
MC CAHAN, MD, WESLEY F	BEDFORD
MC CALL, MD, WILLIAM M	DAUPHIN
MC CANDLESS, MD, DAVID P	VENANGO
MC CANDLESS, MD, WARREN J	VENANGO
MC CANN, MD, WILLIAM D	LANCASTER
MC CARREN, DO, DONALD M	MONTGOMERY
MC CARRON, MD, DANIEL J	PHILADELPHIA
MC CARTER, MD, PAMELA F Y	MIFFLIN/JUNIATA
MC CARTER JR, MD, THOMAS G	PHILADELPHIA
MC CARTHY, DO, MATTHEW T	ERIE
MC CARTHY III, MD, JOHN J	ALLEGHENY
MC CARTNEY, MD, RONALD L	ERIE
MC CARTY, MD, CHRISTINE M	DAUPHIN

MC CAULEY, MD, WILLIAM C	LYCOMING
MC CAUSLAND, JULIE B	STUDENT
MC CAUSLAND, MD, PAUL J	DELAWARE
MC CENSKY, MD, GAIL M	ALLEGHENY
MC CHESNEY JR, MD, CHARLES T	CHESTER
MC CLAIN, MD, CHARLES B	MIFFLIN/JUNIATA
MC CLAIN, DO, DIANE M	BLAIR
MC CLAIN III, MD, EDWARD J	ALLEGHENY
MC CLAIN JR, MD, EDWARD J	ALLEGHENY
MC CLAIN, DO, JAMES B	LYCOMING
MC CLELLAN, MD, R MICHAEL	DELAWARE
MC CLENATHAN, MD, JAMES E	ADAMS
MC CLINTOCK, MD, W CREIGHTON	ALLEGHENY
MC CLOSKEY, MD, DAVID S	DELAWARE
MC CLOSKEY, MD, RICHARD C	ALLEGHENY
MC CLOSKEY, MD, RICHARD V	PHILADELPHIA
MC CLOSKEY, MD, SISTER ANN M	SCHUYLKILL
MC CLOSKEY, DO, TIMOTHY J	LYCOMING
MC CLOWRY, MD, JAMES T	ALLEGHENY
MC CLOY, MD, MERRITT J	WESTMORELAND
MC CLUNG, MD, LARRY S	WESTMORELAND
MC CLURE, CHARLES P	STUDENT
MC CLURE, MD, JONATHAN K	BEAVER
MC CLURE, MD, THOMAS A	ALLEGHENY
MC CLURE, MD, THOMAS D	WESTMORELAND
MC CLUSKEY, MD, LEO F	PHILADELPHIA
MC COLLUM, MD, GEORGE R	ALLEGHENY
MC COLLUM, MICHAEL J	STUDENT
MC COMBS, MD, ELAINE M	MONTGOMERY
MC COMBS, MD, PETER R	MONTGOMERY
MC COMBS, MD, RAY D	ERIE
MC CONAHY, MD, JOHN G	LAWRENCE
MC CONNEL JR, MD, CHARLES S	LEHIGH
MC CONNELL, MD, BRIAN A	ALLEGHENY
MC CONNELL JR, MD, EDWARD L	PHILADELPHIA
MC CONVILLE, MD, JOHN H	YORK
MC CORD, MD, JAMES A	MONTGOMERY
MC CORMACK, MD, PATRICIA A	LACKAWANNA
MC CORMACK, MD, THOMAS M	PHILADELPHIA
MC CORMICK, DO, ALICE	WAYNE/PIKE
MC CORMICK, DO, DANIEL J	PHILADELPHIA
MC CORMICK, MD, GEORGE M	CENTRE
MC CORMICK, MD, JOHN L	PHILADELPHIA
MC CORMICK, MD, LEE H	ALLEGHENY
MC COY, MD, ANDREA C S	DAUPHIN
MC COY, MD, ROBERT L	NORTHAMPTON
MC COY, MD, THOMAS D	INDIANA
MC COY III, MD, WILLIAM H	ALLEGHENY
MC CREARY III, MD, THOMAS W	BEAVER
MC CULLOUGH, DO, HELEN M	DELAWARE
MC CULLOUGH JR, MD, JAMES L	LEHIGH
MC CUNE, MD, ANN B	ALLEGHENY
MC CUNE, MD, WALLACE G	PHILADELPHIA
MC CURDY, MD, DINO E P	PHILADELPHIA
MC CURDY, MD, RICHARD R	DELAWARE
MC CURLEY, SCOTT D	STUDENT
MC CUSKER, MD, FRANCIS X	MONTGOMERY
MC DAID, PATRICK J	STUDENT
MC DAVID, MD, JOSHUA D	ALLEGHENY
MC DERMIT, MD, JOHN R	PHILADELPHIA
MC DERMOTT, MD, ROBERT W	ALLEGHENY
MC DONALD, MD, HERBERT M	LACKAWANNA
MC DONALD, MD, KENNETH M	LEHIGH
MC DONALD, MD, LESTER J	LACKAWANNA
MC DONALD, MD, MARILYN R	NORTHAMPTON
MC DONALD JR, DO, JAMES F	PHILADELPHIA
MC DONALD JR, MD, ROBERT H	ALLEGHENY
MC DONNELL-DATTILO, MD, COLLEEN	ALLEGHENY
MC DONOUGH, MD, GERARD A	LEHIGH
MC DONOUGH, MD, KATHLEEN M	LANCASTER
MC DOUGALL, MD, WILLIAM A	ALLEGHENY
MC DOWELL, MD, EDWARD P	INDIANA
MC DOWELL, DO, JAMES P	ALLEGHENY
MC DOWELL, MD, MARY J	ALLEGHENY
MC DOWELL, MD, RICHARD M	DELAWARE
MC DOWELL, DO, WILLIAM G	MERCER
MC ELHATTAN, EXEC SEC, RITA	CLARION
MC ELRATH, JAMIE R	STUDENT
MC ELREE, MD, JAMES C	MERCER
MC ELREE JR, MD, FRANK E	MERCER
MC ELROY, MD, PHILIP K	MONTGOMERY
MC ELWAIN, MD, MARIANN C	ALLEGHENY
MC EVOY, MD, ROBERT F	NORTHAMPTON
MC FADDEN, MD, DEBRA R	WESTMORELAND
MC FADDEN, DOMINIC J	STUDENT
MC FARLAND, MD, JAMES J	LUZERNE
MC FARLAND, MD, MALCOLM D	PHILADELPHIA
MC GANN, MD, KATHLEEN A	PHILADELPHIA
MC GANNON, MD, PATRICK K	YORK
MC GARR, MD, JANET A	ALLEGHENY
MC GARRITY, MD, SUSAN J	LEBANON
MC GARRY, MD, THOMAS F	BUCKS
MC GARVEY, MD, EILEEN F	BUCKS
MC GARVEY, MD, JOSEPH F	BUCKS
MC GARVEY, MD, RICHARD N	ALLEGHENY
MC GAVIC, MD, JOHN S	MONTGOMERY
MC GEADY, MD, STEPHEN J	PHILADELPHIA
MC GEARY, MD, LESTER E	WESTMORELAND
MC GEE, MD, DAVID M	ERIE
MC GEE, MD, ELIZABETH L	MONTGOMERY
MC GEE, MD, MICHAEL J	LANCASTER
MC GEE JR, MD, JOSEPH P	DELAWARE
MC GEEHAN, MD, JOHN F	LACKAWANNA
MC GEEHAN, MD, JOHN T	CHESTER
MC GEEHAN, MD, PAUL A	ERIE
MC GEHEE, MD, EDWARD H	PHILADELPHIA
MC GEORGE, MD, FRANCIS R	ALLEGHENY
MC GILL, MD, HERMAN I	PHILADELPHIA
MC GILL, MD, REGINA B	DAUPHIN
MC GILL, MD, RITA L	ALLEGHENY
MC GINLEY, MD, GEORGE W	LEHIGH
MC GINN, JOHNATHAN D	STUDENT
MC GINNIS, MD, ANDREW W	DELAWARE
MC GINNIS, MD, DAVID E	PHILADELPHIA
MC GINTY JR, JAMES J	STUDENT
MC GLAMERY, MD, MURIEL E	PHILADELPHIA
MC GLAUGHLIN, MD, SHAWN P	UNION
MC GLUMPHY, MD, THOMAS H	MONTGOMERY
MC GLYNN, MD, JAMES T	DELAWARE
MC GONIGAL, MD, MICHAEL P	ALLEGHENY
MC GORRIAN, MD, GRACE M	ALLEGHENY
MC GOVERN, MD, BRIAN R	DELAWARE
MC GOVERN JR, MD, THOMAS M	BRADFORD
MC GOWAN, MD, DAVID G	PHILADELPHIA
MC GOWAN, MD, TRACY A	MONTGOMERY
MC GOWAN, MD, WILLIAM E	DELAWARE
MC GRATH, MD, GLENN A	MONTGOMERY
MC GRATH, MD, JOSEPH M	DAUPHIN
MC GRATH, DO, ROBERT C	WESTMORELAND
MC GRAW, MD, THOMAS E	PHILADELPHIA
MC GRAW, DO, THOMAS P J	YORK
MC GREGOR, MD, ROBERT S	MONTOUR
MCGROGAN, MD, FRANK P	WESTMORELAND
MC GROGAN, MD, MARTIN J	FAYETTE
MC GUINN, MD, WILLIAM J	YORK
MC GUIRE, MD, FRANCIS E	BEAVER
MC GUIRE, MD, JAMES J	NORTHAMPTON
MC GUIRE, MD, MICHAEL A	ALLEGHENY
MC GUIRE, MD, MICHAEL D	MONTGOMERY
MC GUIRE, MD, RICHARD J	CENTRE
MC GUIRE, MD, THOMAS E	ERIE
MC HARG, MD, MALCOLM L	MONTGOMERY
MC HENRY, MD, D J	YORK
MC HENRY, MD, THOMAS	ALLEGHENY
MC HUGH, MD, ELMER F	ALLEGHENY
MC HUGH, MD, MARY P	PHILADELPHIA
MC HUGH, MD, REGIS W	WESTMORELAND
MC HUGH, MD, RICHARD D	ALLEGHENY
MC ILVAINE, MD, PAUL W	BUCKS
MC INTYRE, CATHERINE J	STUDENT
MC JUNKIN, MD, CHERYL L	ERIE
MC KAY, MD, ROBERT	CAMBRIA
MC KEE, MD, ROBERT E	BUTLER
MC KEE, MD, RODERICK S	PHILADELPHIA
MC KEE, TERESA L	STUDENT
MC KEE, MD, TERRENCE I	YORK
MC KEE, MD, WAYNE O	SOMERSET
MC KEIGHAN, EXEC DIR, DAVID A	DELAWARE
MC KELVY, MD, CONSTANCE C	DELAWARE
MC KENNA, MD, JAMES P	BEAVER
MC KENNA, MD, THOMAS J	CAMBRIA
MC KENNA JR, MD, ERNEST L	MONTGOMERY
MC KENNA, MD, WILLIAM G	PHILADELPHIA
MC KENZIE, MD, HARRY J	CAMBRIA
MC KENZIE, MD, JAMES G	FRANKLIN
MC KENZIE, MD, STEVEN E	PHILADELPHIA
MC KERNAN, MD, DANIEL J	ERIE
MC KEOWN JR, MD, JOHN J	PHILADELPHIA
MC KINLEY, MD, DONALD R	CAMBRIA
MC KINLEY, MD, ERIN A	VENANGO
MC KINLEY, MD, RICHARD G	CAMBRIA
MC KINLEY, MD, WAYNE S	JEFFERSON
MC KINLEY, MD, WILLIAM M	CLARION
MC KINNEY, DANA R	STUDENT
MC KINNEY, MD, HENRY D	BLAIR
MC KINSTRY, MD, ROBERT B	CHESTER
MC KNIGHT, MD, CRAIG E	ALLEGHENY
MC KNIGHT, MD, LANCESS	DELAWARE
MC LANE III, CLYDE	STUDENT
MC LAUCHLAN, GAIL L	STUDENT
MC LAUGHLIN, MD, EDWARD	DELAWARE
MC LAUGHLIN, MD, EDWARD D	PHILADELPHIA
MC LAUGHLIN, MD, FRANK W	LANCASTER
MC LAUGHLIN, MD, GEORGE E	PHILADELPHIA
MC LAUGHLIN, DO, JAMES R	VENANGO
MC LAUGHLIN, MD, JAMES T	ALLEGHENY
MC LAUGHLIN, DO, JOHN P	DAUPHIN
MC LAUGHLIN, MD, RAYMOND S	CHESTER
MC LAUGHLIN, MD, THOMAS W	SCHUYLKILL
MC LAUGHLIN, MD, WILLIAM B	ALLEGHENY
MC LAUGHLIN JR, DO, WILLIAM M	LUZERNE
MC LEAN, MD, GORDON K	ALLEGHENY
MC LEAN, MD, JAMES J	BERKS
MC LELLAN JR, MD, THOMAS G	FAYETTE
MC LENNAN, MD, GORDON	DELAWARE
MC LEOD, MD, RODERICK R	ARMSTRONG
MC LIN, MD, LEON N	YORK
MC LINTOCK, GLENN R	STUDENT
MC LOUGHLIN, MD, PATRICK T	BUCKS
MC MAHON, MD, PATRICK C	MONTGOMERY
MC MAHON, MD, WILLIAM J	WASHINGTON
MC MAHON JR, MD, JOSEPH F	NORTHAMPTON
MC MANUS, STEPHEN W	STUDENT
MC MASTER, MD, JAMES H	ALLEGHENY
MC MILLAN, MD, DEBORAH M	YORK
MC MILLAN, MD, DONALD L	ALLEGHENY
MC MILLAN, MD, JAMES E	ALLEGHENY
MC MILLAN, MD, WILLIAM B	ALLEGHENY
MC MILLEN, MD, JAMES I	DAUPHIN
MC MONAGLE, MD, CAREY L	FAYETTE
MC MULLIN, MD, DANA F	STUDENT
MC MULLEN, TRACY L	STUDENT
MC MURTRY, MD, STACIE A	PHILADELPHIA
MC NABB, MD, DANIEL M	LACKAWANNA
MC NALL, MD, PEARL G	ALLEGHENY
MC NAMARA, MD, CYNTHIA F	PHILADELPHIA
MC NAMARA, MD, J ARCH	PHILADELPHIA
MC NAMARA, MD, ROBERT M	MONTGOMERY
MC NAMEE SR, MD, WILLIAM B	DELAWARE
MC NEAL, AMY R	STUDENT
MC NEELY, MD, BONNIE L	CAMBRIA
MC NEIL, MD, PETER E	NORTHMBRLAND
MC NEIL-JACOBI, MD, ATHOLE G	PHILADELPHIA
MC NEILL, DIANNE M	STUDENT
MC NEILL, MD, DONALD B	ERIE
MC NELLIS, MD, DONALD R	NORTHAMPTON
MC NETT, MD, DALE L	WARREN
MC NIESH, MD, LAWRENCE M	CAMBRIA
MC NULTY, MD, BARBARA M	ALLEGHENY
MC NULTY, MD, LARRY P	ALLEGHENY
MC NULTY, MD, TIMOTHY P	BEAVER
MC NUTT, MD, FRANK H	ARMSTRONG
MC PEAK, MD, VINCENT J	PHILADELPHIA
MC PHERSON, MD, ELIZABETH W	ALLEGHENY
MC QUILLEN, MD, KEMEDY K	ALLEGHENY
MC SORLEY, MD, JOHN	ALLEGHENY
MC SORLEY, MD, MARYANN BIDI	PHILADELPHIA
MC TAMMANY, MD, J ROBERT	BERKS
MC TIGHE, MD, ARTHUR H	UNIONMC VAY, MD, EDWARD J
MC VAY, MD, WILLIAM J	ALLEGHENY
MC WILLIAMS, MD, FRED D	WESTMORELAND
MEADAA, MD, REYMOND	PHILADELPHIA
MEADE, MD, THOMAS D	LEHIGH
MEADOWCROFT, MD, JAMES A	MONTGOMERY
MEADOWS, MD, ANNA T	PHILADELPHIA
MEALS, MD, MARGARET	ALLEGHENY
MEARS, MD, DANA C	ALLEGHENY
MEARS, MD, ELMER E	BUCKS
MEARS, MD, VIRGINIA G	LANCASTER
MEBANE, MD, TOM S	CENTRE
MEBANE III, MD, TOM S	CENTRE
MECCA, MD, DONATO D	LACKAWANNA
MECCA, MD, JOHN J	LEHIGH
MECKLER, MD, DAVID I	PHILADELPHIA
MECS, MD, SANDOR	ALLEGHENY
MEDDEN, MD, EDWIN J	MCKEAN
MEDIC JR, DO, DANIEL	WESTMORELAND
MEDICH, MD, GEORGE F	BEAVER
MEDINA, MD, RODRIGO D	CARBON
MEDINGER, MD, FRED G	PHILADELPHIA
MEDLOCK, MD, JAMES B	LAWRENCE
MEDWAY, MD, MARC J	MONTGOMERY
MEDWICK, DO, DENISE M	ALLEGHENY
MEDWICK, DO, GERALD R	ALLEGHENY
MEEHAN, MD, JOHN J	PHILADELPHIA
MEEHAN, MD, KATHLEEN M	NORTHAMPTON
MEENAN, MD, DANIEL R	CAMBRIA
MEER, JOHN F	STUDENT
MEERAN, MD, M MOHAMED	SCHUYLKILL
MEGALUDIS, MD, ALEXIS M	ALLEGHENY
MEGIVERN, MD, DANIEL G	DAUPHIN
MEGLI, JOEL D	STUDENT
MEHALICK, DO, PAMELA G	DELAWARE
MEHARG JR, MD, JOHN G	BERKS
MEHDI, MD, IFTIKHAR J	DAUPHIN
MEHLMAN, MD, THOMAS W	CUMBERLAND
MEHOK, MD, RONALD G	ALLEGHENY
MEHROK, MD, HARPAUL S	LEHIGH
MEHTA, AMISH M	STUDENT
MEHTA, MD, BHARAT K	NORTHAMPTON
MEHTA, MD, DEVENDRA I	PHILADELPHIA
MEHTA, MD, HARSHAD	ALLEGHENY
MEHTA, MD, NIHARIKA D	COLUMBIA
MEHTA, MD, NIKUNJ P	MONTGOMERY
MEHTA, MD, PANKAJ	LYCOMING
MEHTA, MD, RAJESH M	ALLEGHENY
MEHTA, MD, RAVINDRA K	ALLEGHENY
MEHTA, MD, SANJAY M	DAUPHIN
MEHTA, MD, SUNIL K	MERCER
MEHTA, MD, YOGIN P	MIFFLIN/JUNIATA
MEHTA, MD, YOGINI R	ALLEGHENY
MEIKLE, MD, CHARLES E	BRADFORD
MEINDL, MD, GEORGE T	WASHINGTON
MEISLER, MD, WILLIAM J	ALLEGHENY
MEISNER, MD, DENNIS J	ALLEGHENY
MEISTER, MD, DONALD G	ALLEGHENY
MELADA, MD, GARY A	ALLEGHENY
MELAMED, MD, BRIAN R	LANCASTER
MELANI, MD, KENNETH R	ALLEGHENY
MELDRUM, MD, ROBERT W	COLUMBIA
MELICK, MD, JUDITH E	PHILADELPHIA
MELIN, MD, JEFFREY M	PHILADELPHIA
MELITO, MD, BRIAN V	MONTGOMERY
MELLENGAMP, MD, ERIC J	LYCOMING
MELLER, MD, MENACHEM M	PHILADELPHIA
MELLER, MD, STEVEN	MONTGOMERY
MELLI, MD, MARIA G	DELAWARE
MELLINGER, MD, RICHARD W	LANCASTER
MELLINS, MD, ELIZABETH D	PHILADELPHIA
MELLON, MD, ROBERT	BERKS
MELLON JR, MD, LAWRENCE J	DELAWARE
MELMAN, MD, JAY E	LEHIGH
MELNICK, MD, HOWARD B	LEBANON
MELNICK, MD, JOSEPH L	PHILADELPHIA
MELNICK, MD, SANDY D	PHILADELPHIA
MELOTTI, MICHELLE K	STUDENT
MELOTTI, MD, PETER M	ALLEGHENY
MELOY, MD, THOMAS R	HUNTINGDON
MELTZER, MD, ARTHUR H	DELAWARE
MELTZER, MD, DAVID	MONTGOMERY
MELTZER, MD, MICHELE S	PHILADELPHIA
MELVIN, MD, JOHN L	PHILADELPHIA
MEMARZADEH, SANAZ	STUDENT
MEMON, MD, MUHAMMAD A	ALLEGHENY
MEMON, MD, PARVEZ A	BERKS
MENA, MD, LILIA D	MONTGOMERY
MENACKER, MD, SHERYL J	BUCKS
MENCHEY, MD, MILTON J	YORK
MENCIA, MD, PEDRO R	WAYNE/PIKE
MENDEL, MD, HOWARD G	PHILADELPHIA
MENDEL, MD, KENNETH D	DELAWARE
MENDEL, MD, RICHARD C	PHILADELPHIA
MENDELL, MD, THEODORE H	PHILADELPHIA
MENDELMAN, MD, PAUL M	MONTGOMERY
MENDELSOHN, MD, EUGENE	BERKS
MENDELSOHN, KATHLEEN D	STUDENT
MENDELSON, MD, ELLEN B	ALLEGHENY
MENDELSON, MD, LAWRENCE S	PHILADELPHIA
MENDELSON, MD, MYER	PHILADELPHIA
MENDELSON, MD, S ROBERT	ALLEGHENY
MENDELSSOHN, MD, EDWIN	PHILADELPHIA
MENDELSSOHN, MD, SAUL	LUZERNE
MENDEZ, MD, LEONARDO	PHILADELPHIA
MENEELY, MD, ALFRED W	DAUPHIN
MENGEL, MD, ROGER G	BERKS
MENGES JR, MD, JOB F	BERKS
MENIN, MD, RICHARD A	PHILADELPHIA
MENIN, MD, WILLIAM	PHILADELPHIA
MENIO, MD, GREGORY J	MONROE
MENIO, MD, JOHN N	LUZERNE
MENKOWITZ, MD, BRUCE J	MONTGOMERY
MENKOWITZ, MD, ELLIOT	MONTGOMERY
MENNA, MD, VINCENT J	BUCKS
MENON, MD, VENU G	PHILADELPHIA
MENOUTIS, JOHN K	STUDENT
MENSCHIK, ELLIOT D	STUDENT
MENTYKA, MD, ROBERT A	CENTRE
MENZA, MD, ANTHONY G	MONROE
MENZEL, MD, PAUL H	LACKAWANNA
MENZIES JR, MD, WILLIAM C	MERCER
MERCADER, MD, LUIS	PHILADELPHIA
MERCADER, MD, VIRGINIA	PHILADELPHIA
MERCADO, MD, MODESTO G	LEHIGH
MERCIER, MD, EDWARD E	ERIE
MERCOGLIANO, MD, GIANCARLO	MONTGOMERY
MERCUGLIANO, MD, MARIANNE	PHILADELPHIA
MERCURIO, MD, RICHARD A	ARMSTRONG
MERCURIO, MD, TERESA	BERKS
MERENSTEIN, MD, JOEL H	ALLEGHENY
MERING, MD, THOMAS W	GREENE
MERING JR, MD, JAMES H	ALLEGHENY
MERKIN, MD, ALVIN	PHILADELPHIA
MERKLE, MD, LARRY N	LEHIGH
MERLIN, MD, KEITH S	MONTGOMERY
MERLIN, MARK A	STUDENT
MERLO, DO, FRANCIS A	WAYNE/PIKE
MEROLA, MD, JOSEPH C L	NORTHAMPTON
MERRIMAN, MD, W CLAIR	BEAVER
MERSHON, MD, CHARLES R	LANCASTER
MERSKY, MD, MARTIN R	BUCKS
MERSKY, MD, STEVEN A	PHILADELPHIA
MERSON, MD, ERICH R	CHESTER
MESCHIEVITZ, MD, CARLTON K	MONROE
MESETE, MD, A FRANCIS	DELAWARE
MESHKOV, MD, ARNOLD B	PHILADELPHIA
MESMER, MD, ROGER E	WARREN
MESSINA, DO, MICHAEL P	MERCER
MESSMER, MD, JOHN J	LEBANON
MESSNER, MD, JEAN T	DAUPHIN
MESSNER, MD, KENNETH H	LANCASTER
MESSNER, KEVIN L	STUDENT
MESSORI, MD, DIVO A	PHILADELPHIA
META, MD, LOUIS D	ALLEGHENY
METCALFE, MD, MARC F	ALLEGHENY
METHRATTA, MD, SOSAMMA T	PHILADELPHIA
METKUS, MD, FRANCIS M	BUCKS
METRO JR, MD, DAVID G	STUDENT
METRY, MD, NAWAL G	CHESTER
METZGER, MD, PAUL C	LACKAWANNA
MEUSBURGER, MD, CHARLES E	PHILADELPHIA
MEUSER, MD, ROBERT M	BEAVER
MEYER, MD, ALLEN E	DELAWARE
MEYER, MD, DAVID G	WESTMORELAND
MEYER, MD, JAMES S	PHILADELPHIA
MEYER, MD, MARK W	BEAVER
MEYER, MD, THOMAS M G	DELAWARE
MEYERS, MD, FREDERIC A	CHESTER
MEYERS, MD, JOHN L	BERKS
MEYERS, MD, KARL R	PHILADELPHIA
MEYERS, MD, PAUL T	CAMBRIA
MEYERS, MD, ROBERT W	PHILADELPHIA
MEYERSON, MD, ARTHUR T	PHILADELPHIA
MEZEY, MD, ALAN L	PHILADELPHIA
MEZZANOTTE, MD, JOHN J	PHILADELPHIA
MIANO, MD, LIDIA	BEAVER
MIANO, MD, MICHELE A	PHILADELPHIA
MIASKIEWICZ, MD, STASIA L	ALLEGHENY

MICAILY, MD, BIZHAN	PHILADELPHIA
MICALI, MD, ILLIANA D	PHILADELPHIA
MICCHIA JR, JOSEPH M	STUDENT
MICEK, MD, EDWARD W	PHILADELPHIA
MICHAEL, DO, CHRISTINA S	PHILADELPHIA
MICHAEL, MD, DWIGHT I	ADAMS
MICHAEL, MD, JOSEPH T	ALLEGHENY
MICHAELS, MD, BERNARD I	ALLEGHENY
MICHAELS, MD, MILTON M	ALLEGHENY
MICHAELSON, MD, CAROLYN Z	PHILADELPHIA
MICHAELSON, MD, JANET M	MONTGOMERY
MICHAELSON, MD, THOMAS C	CHESTER
MICHALAK, MD, DENNIS M W	ERIE
MICHALAK, MD, WILLIAM A	LUZERNE
MICHALEK, MD, MARIA	DAUPHIN
MICHALOPOULOS, MD, GEORGE K	ALLEGHENY
MICHALS, MD, TIMOTHY J	PHILADELPHIA
MICHAUD, MD, JOSEPH E	CAMBRIA
MICHAUD, MD, LINDA J	PHILADELPHIA
MICHEL, MD, ANDREW C	MONTOUR
MICHEL, MD, ELLIOT M	ALLEGHENY
MICHEL, MD, JOHN P	BEAVER
MICHELSON, MD, ROBERT	MONTGOMERY
MICHELSTEIN, MD, RICHARD D	LUZERNE
MICHIE, MD, ALEXANDER J	MONROE
MICKLER, MD, THOMAS A	MONTGOMERY
MIDDLEMAN, MD, ROSE R	ALLEGHENY
MIDDLETON, MD, DONALD B	ALLEGHENY
MIDDLETON, MD, ROBERT J	COLUMBIA
MIEDZIAK, MD, ANITA I	PHILADELPHIA
MIESZKALSKI, MD, GLENN B	PHILADELPHIA
MIGLIORE, MD, JOSEPH J	LYCOMING
MIGNANO, MD, JOHN E	ALLEGHENY
MIGNOTT, MD, HAROLD L	PHILADELPHIA
MIHELIC, MD, NICHOLAS E	HUNTINGDON
MIKAELIAN, MD, DIRAN O	PHILADELPHIA
MIKAYA, MD, MARTIN L	BRADFORD
MIKE-MAYER, MD, HENRIK	BLAIR
MIKELBERG, MD, ROSE R	PHILADELPHIA
MIKELL, JEFFREY E	STUDENT
MIKESELL, MD, JERRY F	CENTRE
MIKETIC, MD, LINDA M	ALLEGHENY
MIKHAIL, MD, MONA R	ALLEGHENY
MIKITA, MD, JOHN J	ALLEGHENY
MIKLOS, MD, BERNARD G	ALLEGHENY
MIKNEVICH, MD, MARYANN	ALLEGHENY
MIKULLA, MD, JOHN M	ALLEGHENY
MIKUTA, MD, JOHN J	PHILADELPHIA
MILAI JR, MD, AHMED S	ALLEGHENY
MILANI, MD, FRANK A	LACKAWANNA
MILAS, MD, BONNIE L	PHILADELPHIA
MILAZZO, MD, JOHN V	BUCKS
MILCHAK, MD, MARK A	BEAVER
MILES, DO, G BRUCE	NORTHAMPTON
MILEWSKI, MD, FRANCIS J	PHILADELPHIA
MILEWSKI, MD, LEONARD F	DELAWARE
MILICIA, MD, ANTHONY P	PHILADELPHIA
MILKE, MD, DENIS J	DAUPHIN
MILKS, MD, CARL J	WAYNE/PIKE
MILLAR, MD, DEBORAH L	ALLEGHENY
MILLER, MD, ALAN M	MONTGOMERY
MILLER, MD, ALLEN C	PHILADELPHIA
MILLER, MD, ANN C	MONTGOMERY
MILLER, MD, BARBARA A	PHILADELPHIA
MILLER, MD, BRIAN A	BUCKS
MILLER, MD, CARL S	LEBANON
MILLER, MD, CLAUDE J	LEBANON
MILLER, MD, CURT D	DELAWARE
MILLER, MD, CYNTHIA L	PHILADELPHIA
MILLER, MD, D SCOTT	ALLEGHENY
MILLER, MD, DAVID	PHILADELPHIA
MILLER, MD, DAVID H	BUCKS
MILLER, MD, DAVID L	ALLEGHENY
MILLER, MD, DAVID L	CLARION
MILLER, MD, DAVID M	PHILADELPHIA
MILLER, MD, DAVID S	HUNTINGDON
MILLER, MD, DONALD S	MONTGOMERY
MILLER, MD, EARL R	LYCOMING
MILLER, MD, EDWARD B	ALLEGHENY
MILLER, MD, EDWARD J	CARBON
MILLER, MD, FRANCINE J	PHILADELPHIA
MILLER, MD, FRANK L	MONTGOMERY
MILLER, MD, FREDERICK A	ALLEGHENY
MILLER, MD, G GEOFFREY	LUZERNE
MILLER, MD, GLADYS M	PHILADELPHIA
MILLER, MD, GLENN D	PHILADELPHIA
MILLER, MD, HARRY I	ALLEGHENY
MILLER, MD, HERBERT D	ALLEGHENY
MILLER, MD, HERMAN	DELAWARE
MILLER, MD, HOWARD J	POTTER
MILLER, DO, JAMES C	DAUPHIN
MILLER, MD, JAY B	BERKS
MILLER, MD, JEFFREY J	PHILADELPHIA
MILLER, MD, JEFFREY L	PHILADELPHIA
MILLER, DO, JERI L	PHILADELPHIA
MILLER, MD, JEROME	PHILADELPHIA
MILLER, MD, JOHN L	MERCER
MILLER, MD, JOSEPH A	LEHIGH
MILLER, MD, JOSEPH J	FRANKLIN
MILLER, MD, KERRY D	LEHIGH
MILLER, MD, LAWRENCE S	DELAWARE
MILLER, MD, LEE C	DAUPHIN
MILLER, MD, LEE H	BUCKS
MILLER, MD, LEONARD D	PHILADELPHIA
MILLER, DO, LOIS M	MONTOUR
MILLER, MD, MARGARET A	ALLEGHENY
MILLER, MD, MARK A	PHILADELPHIA
MILLER, MD, MATTHEW C	MONTGOMERY
MILLER, MD, MICHAEL D	ALLEGHENY
MILLER, MD, MICHAEL K	ALLEGHENY
MILLER, DO, MORRIS	PHILADELPHIA
MILLER, MD, MYRON D	LEBANON
MILLER, MD, PARRY J	LANCASTER
MILLER, MD, PATRICIA S	ALLEGHENY
MILLER, MD, RALPH J	ALLEGHENY
MILLER, MD, RANDY B	PHILADELPHIA
MILLER, MD, RICHARD E	SCHUYLKILL
MILLER, MD, ROBERT W	BUCKS
MILLER, MD, ROLAND E	ERIE
MILLER, MD, STEPHEN J	ALLEGHENY
MILLER, MD, STEPHEN L	CAMBRIA
MILLER, MD, TERESA B	ALLEGHENY
MILLER, MD, THOMAS J	MONTGOMERY
MILLER, MD, THOMAS L	LANCASTER
MILLER, MD, WAYNE R	NORTHMBRLAND
MILLER, MD, WILLIAM B	ALLEGHENY
MILLER, MD, WILLIAM H	ALLEGHENY
MILLER II, MD, GEORGE C	UNION
MILLER II, MD, TOM R	ERIE
MILLER III, MD, JOHN W	LANCASTER
MILLER III, MD, O FRED	MONTOUR
MILLER JR, MD, CLARENCE M	ALLEGHENY
MILLER JR, MD, IVAN L	ADAMS
MILLER JR, MD, JOHN W	LANCASTER
MILLER JR, MD, WILLIAM B	DAUPHIN
MILLER-SCHAEFFER, MD, CAROL A	SCHUYLKILL
MILLINER, MD, DAVID H	DELAWARE
MILLMAN, MD, DARLENE W	ALLEGHENY
MILLON, MD, S JOHN	MONTOUR
MILLS, MD, BETTY JO A	LYCOMING
MILLS, MD, JOHN W	INDIANA
MILLS, MD, M DUANE	DAUPHIN
MILLS, MD, STEVEN E	STUDENT
MILLS, MD, WILLIAM L	BUCKS
MILLS, EXEC DIR, CAROLINE L	BEAVER
MILNER, MD, ROSS	STUDENT
MILON, MD, CHARLES F	PHILADELPHIA
MILORO, MD, MICHAEL J	PHILADELPHIA
MILROTH, MD, WILLIAM L	FRANKLIN
MILSTEEN, MD, SCOTT A	DAUPHIN
MILSTEIN, MD, HAROLD J	LUZERNE
MILSTEIN, MD, SEYMOUR W	DELAWARE
MILSTEN, MD, RICHARD	PHILADELPHIA
MIN, MD, JUNG T	BEAVER
MIN, MD, TAE C	BEAVER
MINARD, MD, WILLIAM D	MONTGOMERY
MINCZAK, BOHDAN M	STUDENT
MINEHART, MD, CHARLES R	BERKS
MINEHART, MD, JOHN R	PHILADELPHIA
MINELLA, MD, RICCI A	ALLEGHENY
MINEO, MD, CYRUS L	CHESTER
MINERVA, MD, FELICISIMA B	PHILADELPHIA
MINES, MD, SAMUEL C	ALLEGHENY
MINGEY, MD, DEBORAH L	ERIE
MINGEY, MD, JOHN R	ERIE
MINGRONI, DO, JULIUS A	PHILADELPHIA
MINION, MD, STEVEN L	PHILADELPHIA
MINK, MD, KENNETH R	ERIE
MINN, MD, FREDRICK L	MONTGOMERY
MINNARD, MD, EMERY A	PHILADELPHIA
MINNICH, MD, KEITH A	BERKS
MINNICH, MD, MARIE E	MONTOUR
MINNICH, MD, STEPHEN J	MONTOUR
MINNO, MD, ALEXANDER M	ALLEGHENY
MINO, MD, DAVID E	BUCKS
MINO, MD, ROBERT D	MONTGOMERY
MINOR, MD, MARK R	HUNTINGDON
MINORA, MD, BARRY A	LACKAWANNA
MINORA, MD, MICHAEL A	LACKAWANNA
MINORA, MD, THOMAS L	LACKAWANNA
MINTEER, MD, JEFFREY F	WASHINGTON
MINTEER JR, DO, DONALD W	ARMSTRONG
MINTO, EXEC SEC, DEBBIE	INDIANA
MINTON, MD, MICHAEL D	ALLEGHENY
MINTON, MD, RUSSELL F	PHILADELPHIA
MINTZ, MD, HOLLY P	ALLEGHENY
MINTZER, MD, DAVID M	PHILADELPHIA
MINTZER, DO, HARRY D	LYCOMING
MIR, MD, DAVID J	ERIE
MIR, MD, TAHIR U	INDIANA
MIRA, MD, ALLAN J	CUMBERLAND
MIRABILE, MD, ROBERT J	MONTGOMERY
MIRAGLIA, MD, RICHARD J	MONROE
MIRALIAKBARI, REZA	STUDENT
MIRANDA, MD, AURORA M	ALLEGHENY
MIRANDA, MD, CESAR P	BUTLER
MIRANDA, FERNANDO E	STUDENT
MIRARCHI, MD, VINCENZO	NORTHMBRLAND
MIRCHANDANI, MD, HARESH G	PHILADELPHIA
MIRRO, MD, BETTY J	ALLEGHENY
MIRSKY, MD, HOWARD A	YORK
MIRSKY, MD, ROBERT S	BUCKS
MIRZA, MD, FARRUKH	PHILADELPHIA
MIRZA, MD, MOHAMMAD R	LYCOMING
MISAGE, MD, JOHN R	ALLEGHENY
MISCHLER, MD, FORREST C	ERIE
MISENHIMER, MD, MARTIN D	LEHIGH
MISHALOVE, MD, R DAVID	DELAWARE
MISHEL, MD, HENRY S	MONTGOMERY
MISHKIN, MD, MARK H	LEHIGH
MISHKIN, MD, MARK M	PHILADELPHIA
MISHRA, PRAGYA PM	STUDENT
MISHRA, MD, RANDHIR	CLINTON
MISKOVSKY, SHANA N	STUDENT
MISKULIN, JUDIANN	STUDENT
MISTRY, MD, MEHERWAN J	WAYNE/PIKE
MITAL, MD, MOHAN S	CAMBRIA
MITAL, MD, NIRMAL G	CAMBRIA
MITCHELL, MD, ARTHUR B	LUZERNE
MITCHELL, MD, DAVID R	ALLEGHENY
MITCHELL, MD, FENTON M	ALLEGHENY
MITCHELL, MD, HAROLD L	ALLEGHENY
MITCHELL, MD, HENRY	INDIANA
MITCHELL, MD, JOHN F	LEHIGH
MITCHELL, MD, JONI M	BRADFORD
MITCHELL, MD, ROBERT M	PHILADELPHIA
MITCHELL, MD, WILLIAM J	FAYETTE
MITNICK, MD, PAUL D	BERKS
MITRA, MD, ATIN K	ERIE
MITRE, MD, BLIMA K	ALLEGHENY
MITRE, MD, RICARDO J	ALLEGHENY
MITRO, DO, ROBERT N	ALLEGHENY
MITRO, MD, WILLIAM	ALLEGHENY
MITROS, MD, MARK M	ALLEGHENY
MITTAL, MD, BASANT K	NORTHMBRLAND
MITTAL, MD, SUNEET	PHILADELPHIA
MITTELDORF, MD, STEPHEN E	PHILADELPHIA
MITTELL, MD, DAVID C	WASHINGTON
MITTICA, NICHOLAS M	STUDENT
MITTMAN, MD, DEAN	LACKAWANNA
MITZEL, DO, TIMOTHY S	ALLEGHENY
MIURA, MD, KAREN K	PHILADELPHIA
MIX, MD, WILLIAM A	ERIE
MIYAMOTO, MD, CURTIS T	DELAWARE
MIZE, DAVID S	STUDENT
MIZIN, MD, LAKSHMI D J	LACKAWANNA
MLECKO, MD, LAWRENCE M	ALLEGHENY
MLINAR, LAURA S	STUDENT
MNUSKIN, MD, DMITRIY	ALLEGHENY
MOATS, MD, ANTHONY W	ALLEGHENY
MOBARAKAI, MD, NEVILLE K	ERIE
MOBERG, MD, F BARRIE	LANCASTER
MOCH, ANNE L	STUDENT
MOCK, MD, GREGORY D	CAMBRIA
MOCLOCK, MD, MICHAEL A	LUZERNE
MODARRESS, MD, JOHN Y	SCHUYLKILL
MODERY, MD, MARSHA E	ALLEGHENY
MODI, MD, ASHESH I	PHILADELPHIA
MODI, MD, JASHWANT B	ALLEGHENY
MODI, JIGNYA J	STUDENT
MODY, MD, SMITA S	SCHUYLKILL
MOERKIRK, MD, GEORGE E	LEHIGH
MOES, DO, JACQUELINE M	PHILADELPHIA
MOFFITT, MD, JOHN J	PHILADELPHIA
MOFFITT, MD, VINCENT J	BERKS
MOFFITT JR, MD, GEORGE R	DAUPHIN
MOFFSES, MD, GARABED H	PHILADELPHIA
MOGERMAN, MD, JEFFREY A	LACKAWANNA
MOGHADAM, MD, ABDOL NABI	PHILADELPHIA
MOGHADAM, MD, EILEEN S	PHILADELPHIA
MOGIL, MD, ROBERT A	PHILADELPHIA
MOGUL, MD, ROBERT	BUCKS
MOHAMADI, MICHELE S	STUDENT
MOHAMED, MD, YASSER A	PHILADELPHIA
MOHAMED-ALI, MD, ABUL-KASSIM	LEHIGH
MOHAN, MD, BRIJ	NORTHAMPTON
MOHAN, MD, CHANDRA	LUZERNE
MOHAN, MD, FRANCIS P	SCHUYLKILL
MOHAN, MD, KRISHNA K	PHILADELPHIA
MOHLER, MD, J HAROLD	LANCASTER
MOHYUDDIN, MD, MOIZ	MONROE
MOIDEL, MD, ROBERT A	MONTGOMERY
MOKRYNSKI, MD, GREG	PHILADELPHIA
MOKYCHIC, MD, WALTER E	LUZERNE
MOLDOFSKY, MD, PHILIP J	PHILADELPHIA
MOLINA, MD, ANGELA	ALLEGHENY
MOLINARI, MD, WILLIAM J	MONTGOMERY
MOLL, MD, ALISON	YORK
MOLL, MD, DAVID C	BUCKS
MOLL, MD, GEORGE A	PHILADELPHIA
MOLL, MD, THOMAS B	BERKS
MOLLICK, MD, JAMES A	MONTGOMERY
MOLLICK, MD, JAMES L	MONTGOMERY
MOLLOY, MD, PATRICIA T	PHILADELPHIA
MOLLOY, MD, PETER J	ALLEGHENY
MOLLURA, MD, JOSEPH A	WESTMORELAND
MOLONEY, MD, JOSEPH D	DAUPHIN
MOMAN JR, MD, LAWRENCE C	ALLEGHENY
MOMIN, MD, MALIK N	DAUPHIN
MONAGHAN, MD, BRUCE A	PHILADELPHIA
MONAHAN, MD, DANIEL J	ALLEGHENY
MONAHAN, FRANCINE M	STUDENT
MONAHAN, MD, GEORGE R	MONTGOMERY
MONAHAN, MD, MARYELLEN R O	LACKAWANNA
MONASTERIO, MD, JOSE R	CHESTER
MONCMAN, DO, MICHAEL-GERARD	BLAIR
MONDALA-OCBO, MD, ELISA V	BERKS
MONDEREWICZ, KATHLEEN M	STUDENT
MONDERO, DO, NANCY A	DELAWARE
MONDZELEWSKI, MD, JAMES P	ALLEGHENY
MONGIA, SUMEDHA	STUDENT
MONGIARDO, JAY P	STUDENT
MONHEIT, MD, RICHARD S	PHILADELPHIA
MONK, MD, JOHN S	YORK
MONK JR, MD, JOHN S	YORK
MONKOWSKI, MD, ALFRED M	BUCKS
MONSOUR, MD, GEOFFREY B	WESTMORELAND
MONSOUR, MD, HELEN S	WESTMORELAND
MONSOUR, MD, MIROYA J	ALLEGHENY
MONSOUR, MD, ROBERT G	WESTMORELAND
MONSOUR, MD, ROY CHARLES	WESTMORELAND
MONSOUR, MD, ROY CHRISTOPHER	WESTMORELAND
MONSOUR, MD, WILLIAM J	WESTMORELAND
MONTAG, MARK C	STUDENT
MONTAGUE, MD, JAMES W	LYCOMING
MONTALBO, MD, ANTONIO A	CENTRE
MONTANER, MD, CARMEN G	LEHIGH
MONTANER, MD, JOSE L	DAUPHIN
MONTANTE, STEVEN J	STUDENT
MONTE, MD, D MARIE	CHESTER
MONTEFORTE, MD, MARK J	PHILADELPHIA
MONTEIRO, MD, DENNIS T	PHILADELPHIA
MONTELEONE, MD, PAUL N	CAMBRIA
MONTELLA, MD, MICHAEL	LACKAWANNA
MONTELLO, MD, JOAN M	CUMBERLAND
MONTESANO, MD, ANGELICA T	PHILADELPHIA
MONTGOMERY, MD, BRUCE B	CUMBERLAND
MONTGOMERY, MD, ERNEST J	ARMSTRONG
MONTGOMERY, MD, KARLA J	PHILADELPHIA
MONTGOMERY, MD, MARK R	FAYETTE
MONTGOMERY, MD, OWEN C	PHILADELPHIA
MONTGOMERY, MD, PATRICIA A	DELAWARE
MONTGOMERY, MD, THADDEUS L	PHILADELPHIA
MONTOURIS, MD, ELAINE A	ALLEGHENY
MONTZKA, MD, DAN P	DELAWARE
MONYAK, MD, JOHN G	BEAVER
MONYAK, MD, SANDRA G	ALLEGHENY
MOODY, MD, JACK H	DAUPHIN
MOON, MD, BRIAN W	PHILADELPHIA
MOON, MD, SANGGIU	MERCER
MOON, MD, SUNG B	WESTMORELAND
MOONDA, MD, GULAMHUSAIN	MERCER
MOONEY, MD, BENJAMIN R	YORK
MOONEY, TODD S	STUDENT
MOORE, MD, BARRY B	DAUPHIN
MOORE, MD, CHARLES A	GREENE
MOORE, DO, CHERYL A	ERIE
MOORE, MD, DANIEL W	BUCKS
MOORE, MD, DAVID H	YORK
MOORE, MD, DAVID H	LUZERNE
MOORE, MD, GEORGE W	LAWRENCE
MOORE, MD, JAMES P	ARMSTRONG
MOORE, MD, JAY R	PHILADELPHIA
MOORE, DO, JOHN F	ERIE
MOORE, MD, JOSEPH J	TIOGA
MOORE, MD, LEROY C	ALLEGHENY
MOORE, MD, MATTHEW T	PHILADELPHIA
MOORE, MD, RICHARD A	CAMBRIA
MOORE, MD, TERENCE E	ARMSTRONG
MOORE, MD, TERENCE N	LANCASTER
MOORE JR, MD, JOHN H	PHILADELPHIA
MOORE JR, MD, SAMUEL R	PHILADELPHIA
MOORE SR, MD, ROBERT G	LANCASTER
MOOREVILLE, MD, MICHAEL	DELAWARE
MOORTHY, MD, GITA	YORK
MOOSSY, MD, JOHN J	ALLEGHENY
MORACA, MD, JOHN I	ALLEGHENY
MORAITIS, MD, CONSTANTINE Z	ALLEGHENY
MORALES, MD, DIEGO	PHILADELPHIA
MORALES, MD, FRANCISCO J	LEBANON
MORALES, MD, GLADYS D	NORTHAMPTON
MORALES-PELAEZ, MD, EILEEN S	PHILADELPHIA
MORAN, DO, MARK E	LEHIGH
MORAN JR, MD, THOMAS W	WESTMORELAND
MORANI, MD, ALMA D	PHILADELPHIA
MORANZ, MD, JOEL G	DELAWARE
MORASCO, MD, EDWARD R	LEBANON
MOREAU, MD, CARLOS E	ALLEGHENY
MORELLI, DO, JOSEPH T	MERCER
MORENO, MD, HERMANN A	PHILADELPHIA
MORENO, MD, MANUEL V	LYCOMING
MORESEA, MD, GEORGE A	ALLEGHENY
MORETTO, MD, JOSEPH L	LAWRENCE
MOREY, MD, ARTHUR V	DELAWARE
MORFFI, MD, OSCAR A	LEHIGH
MORGAN, MD, ALLAN V	ALLEGHENY
MORGAN, MD, CORINNE M	MONTGOMERY
MORGAN, MD, JAMES J	MIFFLIN/JUNIATA
MORGAN, MD, JEFFREY F	WARREN
MORGAN, MD, JOHN M	DELAWARE
MORGAN, MD, RUSSELL E	NORTHAMPTON
MORGAN, MD, VINCENT F	BLAIR
MORGAN, MD, WILLIAM F	NORTHAMPTON
MORGAN, MD, YVONNE G	BERKS
MORGAN JR, MD, JAMES W	UNION
MORGAN JR, MD, VERNON W	LACKAWANNA
MORGANROTH, MD, JOEL	PHILADELPHIA
MORGENLANDER, MD, LYNN E	PHILADELPHIA
MORGENSTERN, KENNETH E	STUDENT
MORGENSTERN, MD, STEPHEN A	MONTGOMERY
MORI, MD, GINO	LACKAWANNA
MORI, MD, HUGO	LACKAWANNA
MORITZ, MD, MICHAEL J	PHILADELPHIA
MORITZ, MD, MICHAEL J	YORK
MORITZ, MD, MORDEKHAI	LACKAWANNA
MORK, MD, GUSTAVE W	ERIE
MORLEY, MD, ROBERT R	DELAWARE
MOROCCO, MARK V	STUDENT
MOROHUNFOLA, MD, KEHINDE A	DAUPHIN
MORREELS JR, MD, CHARLES L	YORK
MORRELL, DO, ROGER W	CAMBRIA
MORRIS, MD, ADRIAN J	LACKAWANNA
MORRIS, DARRYL R	STUDENT
MORRIS, MD, DAVID W	ALLEGHENY
MORRIS, MD, DENNIS L	LEHIGH
MORRIS, MD, ELEANOR G	SOMERSET
MORRIS, MD, JON B	PHILADELPHIA
MORRIS, MD, LESLIE E	ALLEGHENY
MORRIS, DO, MATILDA J	MERCER
MORRIS, MD, MICHAEL C	PHILADELPHIA
MORRIS, MD, PATRICIA A	NORTHAMPTON
MORRIS, MD, RICHARD J	DELAWARE

MORRIS, MD, ROBERT S	MONTGOMERY
MORRIS, MD, SHELDON L	DELAWARE
MORRIS JR, MD, JAMES A	DELAWARE
MORRIS JR, MD, ROBERT G	WYOMING
MORRIS JR, DO, WILSON S	LEBANON
MORRISON, MD, ALAN N	LEHIGH
MORRISON, MD, BRUCE W	ALLEGHENY
MORRISON, DAVID M	STUDENT
MORRISON, JEFFREY A	STUDENT
MORRISON, MD, KEVIN S	YORK
MORRISON, LAKE D	STUDENT
MORRISON, MD, SAMUEL S	MONTOUR
MORRISON, MD, WILLIAM B	PHILADELPHIA
MORRISSEY JR, MD, E JAMES	BERKS
MORRONE, DO, CHARLES C	PHILADELPHIA
MORROW, MD, BERT A	BERKS
MORROW, MD, HERBERT J	WESTMORELAND
MORROW, MD, LINDA C	LUZERNE
MORROW, MD, ROBERT A	LEHIGH
MORROW, MD, THAYER K	WESTMORELAND
MORROW GORTON, MD, JILL D	DAUPHIN
MORROW JR, MD, JOHN A	BEAVER
MORROW-CONNELLY, DO, RENEE D	LEHIGH
MORSE, MD, RICHARD J	LEHIGH
MORSE, MD, W SCOTT	ALLEGHENY
MORTEL, MD, RODRIGUE	DAUPHIN
MORTENSEN, ERIC M	STUDENT
MORTIMER, MD, GREGORY P	ALLEGHENY
MORTON, MD, JOHN C	DAUPHIN
MORTON, MD, MARGARET S	ALLEGHENY
MORTON, MD, ROBERT J	WAYNE/PIKE
MOSCH, MD, GEORGE C	POTTER
MOSCH, MD, HERMAN C	POTTER
MOSER, MD, EDWARD N	LYCOMING
MOSER, MD, JOHN C	BERKS
MOSES, MD, BRETT L	BUCKS
MOSES, MD, JAMES M	CAMBRIA
MOSHANG JR, MD, THOMAS	PHILADELPHIA
MOSKOVITZ, MD, MORRY	BEAVER
MOSKOWITZ, MD, BARRY D	ALLEGHENY
MOSLEY, MEHRAN	STUDENT
MOSS, MD, EDWARD R	PHILADELPHIA
MOSS, MD, JOSEPH S	WESTMORELAND
MOSS JR, MD, VASSAR Y	ALLEGHENY
MOST-LEVIN, MD, CAROL	MONTGOMERY
MOSTER, MD, MARK L	PHILADELPHIA
MOSTER, MD, MARLENE R	PHILADELPHIA
MOSTOUFIZADEH, MD, MAHPAREH	ALLEGHENY
MOTEN, MD, MARRIVAM	PHILADELPHIA
MOTLEY, DARLENE M	STUDENT
MOTLEY, MD, JOHN F	MONTGOMERY
MOULTON, MD, MICHAEL P	PHILADELPHIA
MOURADIAN, MD, ROBERT D	STUDENT
MOURY JR, MD, NELSON F	MONTGOMERY
MOWAD, MD, JOSEPH J	MONTOUR
MOXEN, MD, JOHN M	LACKAWANNA
MOY, MD, KAI H	BERKS
MOYER, BRAD K	STUDENT
MOYER, MD, DENNIS L	BUCKS
MOYER, MD, EARL S	DAUPHIN
MOYER, MD, GLENN E	NORTHAMPTON
MOYER, MD, JAMES E	MONROE
MOYER, MD, JOHN F	ALLEGHENY
MOYER, MD, JOHN H	DAUPHIN
MOYER, MD, JOHN P	BUCKS
MOYER, MD, PAUL R	BUCKS
MOYER, MD, RAY A	PHILADELPHIA
MOYER, MD, THELBERT R	ERIE
MOYER JR, MD, DONALD J	ALLEGHENY
MOYER JR, MD, ROBERT D	ALLEGHENY
MOYERS, MD, ROBERT N	CRAWFORD
MOYLAN, MD, JAQUELINE D	PHILADELPHIA
MOYLAN, MD, JOSEPH E	LACKAWANNA
MOZERSKY, DO, ROBERT P	LANCASTER
MRAZ, MD, JAMES E	ERIE
MRAZ, MD, JOHN P	ERIE
MRKICH, MD, ROBERT	CAMBRIA
MRVOS, MD, DIANA L	ALLEGHENY
MRVOS, MD, DONALD M	ALLEGHENY
MSZANOWSKI, MD, EDWIN M	ERIE
MUALLEM, MD, NABIL S	BERKS
MUCCIO, MD, DANIEL J	WESTMORELAND
MUCH, DO, MANDELL J	DELAWARE
MUCHA, MD, STEPHEN J	MONTGOMERY
MUCHLADO, MD, FELIX J	ALLEGHENY
MUDGE, MD, KIMBERLEE	YORK
MUDRICK, MD, DAVID L	DELAWARE
MUELLER, MD, HENRY M	MERCER
MUENKE, MD, MAXIMILIAN	PHILADELPHIA
MUETTERTIES, MD, CRAIG L	DELAWARE
MUFSON, MD, RICHARD A	BUCKS
MUHLENBERG, MD, J PETER	BERKS
MUHLFELDER, MD, WARREN J	BLAIR
MUHONEN, D, OLIVER A	ALLEGHENY
MUIR, DO, SCOTT D	PHILADELPHIA
MUKHERJEE, MD, SHANKER	NORTHAMPTON
MULBERG, MD, ANDREW E	PHILADELPHIA
MULHATTEN, MD, DONALD E	CENTRE
MULHERN, MD, CHARLES B	PHILADELPHIA
MULHERN, MD, LAWRENCE M	ALLEGHENY
MULHOLLAND, MD, S GRANT	PHILADELPHIA
MULINDA, MD, JAMES	PHILADELPHIA
MULL, MD, JOSEPH C	WARREN
MULL, MD, THOMAS D	MONTGOMERY
MULLA, MD, OMAR P	ERIE
MULLEN, MD, JAMES L	PHILADELPHIA
MULLEN, MD, MARK J	PHILADELPHIA
MULLER, MD, ALFONS J	PHILADELPHIA
MULLER, DO, ARTHUR J	DAUPHIN
MULLER, MD, GARY W	PHILADELPHIA
MULLER, MD, H ARNOLD	LEBANON
MULLER, MD, OTTO F	DELAWARE
MULLICK, MD, JOWHERI J	VENANGO
MULLICK, MD, PRABIR K	ALLEGHENY
MULLIGAN, MD, JAMES F	YORK
MULLIGAN, MD, ROBERT L	BERKS
MULLIN JR, MD, EDWARD M	LEHIGH
MULLIN JR, MD, HUGH J	BUCKS
MULVANEY, MD, DENISE A	DELAWARE
MULVIHILL, MD, JOHN J	ALLEGHENY
MUMBAUER, STEVEN W	STUDENT
MUNCHAK JR, MD, JOHN	LEHIGH
MUNDTH, MD, ELDRED D	DELAWARE
MUNIN, MD, MICHAEL C	ALLEGHENY
MUNIR, MD, MOHAMMAD M	NORTHMBRLAND
MUNIR, MD, MUHAMMAD	SCHUYLKILL
MUNLEY, MD, BRIAN J	BUCKS
MUNOZ, MD, JESUS A	PHILADELPHIA
MUNSHOWER, DO, JOHN C	PHILADELPHIA
MUNSHOWER, DO, THOMAS E	CARBON
MUNSON, MD, FREDERICK J	NORTHAMPTON
MUNTHER, MD, ANTOINE S	BERKS
MUNVES, MD, JONATHAN H	NORTHAMPTON
MUNZER, MD, STEVEN J	PHILADELPHIA
MURCEK, MD, MARTIN A	WESTMORELAND
MURDOCH, MD, WINSLOW W	CHESTER
MURDOCK, MD, FRED E	JEFFERSON
MURDOCK, MD, MORTON G	PHILADELPHIA
MUREEBE, MD, LEILA	PHILADELPHIA
MURELLO, MD, DAVID M	FAYETTE
MURILLO, MD, OSCAR	NORTHAMPTON
MURN, MD, ALVIN J	CAMBRIA
MUROFF, DO, ROBERT E	DELAWARE
MURPHEY, MD, SHEILA A	PHILADELPHIA
MURPHEY, MD, STEPHEN M	ALLEGHENY
MURPHY, MD, BARBARA J	DELAWARE
MURPHY, BRIAN J	STUDENT
MURPHY, MD, BRIAN P	LEHIGH
MURPHY, MD, EDITH L	LYCOMING
MURPHY, MD, EDWARD	STUDENT
MURPHY, MD, J THOMAS	MONTGOMERY
MURPHY, MD, JOHN B	PHILADELPHIA
MURPHY, MD, JOHN D	PHILADELPHIA
MURPHY, JOSEPH J	STUDENT
MURPHY, DO, PATRICK	DELAWARE
MURPHY, MD, TERRANCE P	CENTRE
MURPHY, MD, THOMAS W	PHILADELPHIA
MURPHY, DO, WILLIAM C	DELAWARE
MURPHY, MD, WINDELL H A	PHILADELPHIA
MURPHY JR, MD, ARTHUR I	ALLEGHENY
MURPHY JR, MD, ROBERT X	LEHIGH
MURRAY, MD, CHERYL L	YORK
MURRAY, MD, JOHN P	MONTGOMERY
MURRAY, JOSEPH F	STUDENT
MURRAY, MD, MICHAEL F	PHILADELPHIA
MURRAY, DO, MICHAEL L	BUCKS
MURRAY, MD, RICHARD C	CAMBRIA
MURRAY, MD, RICHARD S	BUCKS
MURRAY, MD, STEPHEN R	NORTHAMPTON
MURRAY, MD, THOMAS R	PHILADELPHIA
MURRAY, MD, WILLIAM M	DAUPHIN
MURRAY JR, MD, RICHARD J	YORK
MURRAY-LEISURE, MD, KATHERINE A	LEBANON
MURRELL, WILLIAM D	STUDENT
MURTAGH JR, MD, FREDERICK	PHILADELPHIA
MURTHY, MD, MOLAKALMURU H	ALLEGHENY
MURTHY, MD, MSJ	PHILADELPHIA
MURTLAND, MD, ALBERT M	BRADFORD
MUSA, MD, ALIMAD N	CARBON
MUSGRAVE, MD, ROSS H	ALLEGHENY
MUSGRAVE, MD, STEVEN P	MONTOUR
MUSHO, MD, MICHAEL A	MONTGOMERY
MUSMANNO, MD, MARK C	ALLEGHENY
MUSMANNO, MD, SAMUEL A	ALLEGHENY
MUSSER, MD, BENJAMIN G	DAUPHIN
MUSSER, MD, WILLIAM T	UNION
MUSSER JR, MD, HAROLD E	SOMERSET
MUSSOLINE JR, MD, JOSEPH F	PHILADELPHIA
MUSTIN, MD, ANDREW J	PHILADELPHIA
MUSTOVIC, MD, ELLEN H	ALLEGHENY
MUTHA, MD, SUNITA	ALLEGHENY
MUTHU, MD, AMRUTHAUALLI	PHILADELPHIA
MUTHU, MD, PREM KUMAR	PHILADELPHIA
MUTSCHLER, MD, THOMAS A	ALLEGHENY
MUZZIO, MD, KEVIN R	PHILADELPHIA
MYCHAK, MD, DENNIS R	NORTHMBRLAND
MYEROWITZ, MD, RICHARD L	ALLEGHENY
MYERS, MD, ABRAHAM	PHILADELPHIA
MYERS, MD, ALLEN R	PHILADELPHIA
MYERS, MD, CHARLES E	LUZERNE
MYERS, MD, COLLIN L	YORK
MYERS, MD, DAVID	PHILADELPHIA
MYERS, MD, DONALD L	PHILADELPHIA
MYERS, MD, EUGENE N	ALLEGHENY
MYERS, MD, FREDERICK B	LUZERNE
MYERS, MD, G BRADFORD	YORK
MYERS, MD, GERALD I	ALLEGHENY
MYERS, DO, GERARD A	ALLEGHENY
MYERS, MD, GORDON D	DAUPHIN
MYERS, DO, JOHN H	LANCASTER
MYERS, JOHN J	STUDENT
MYERS, MD, JOHN L	DAUPHIN
MYERS, MD, PHILIP A	BUCKS
MYERS, EXEC SEC, KATHY	ELK/CAMERON
MYERS III, MD, FRANKLIN J	DAUPHIN
MYERSON, MD, RALPH M	PHILADELPHIA
MYRON, MD, CAROL S	ALLEGHENY
MYSTAKAS, MD, FOTIS G	LEBANON

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NABATCHI, MD, AHMAD	CLARION
NABATI, MD, ISMAIL	NORTHAMPTON
NABAVI, MD, ABDOLLAH	CENTRE
NABER, MD, WILLIAM J	MONTOUR
NACHWALTER, RICHARD S	STUDENT
NACK, MD, STEVEN L	MONTGOMERY
NACKLEY, MD, DANIEL A	LUZERNE
NADAL, MD, RAMON B	BUCKS
NADAR, MD, VENKATESH K	DAUPHIN
NADEL, MD, MARCELL-BERNH	PHILADELPHIA
NADER, MD, JOSEPH N	LEHIGH
NADIGA, MD, CHANDRA S	BEAVER
NADLER, MD, DANIEL J	ALLEGHENY
NADLER, MD, LEIGH H	ALLEGHENY
NADLER, MD, M PRINCETON	ALLEGHENY
NADLER, MD, MARCUS P	MONTGOMERY
NADWORNY, MD, HOWARD A	ERIE
NAEGLE, MD, MATTHEW B	CHESTER
NAFZIGER, MD, J CALVIN	LANCASTER
NAGARAJAN, RAJARAM	STUDENT
NAGEL, MD, DAVID B	LYCOMING
NAGELBERG, MD, STEVEN B	MONTGOMERY
NAGELKIRK, MD, JOAN E	ALLEGHENY
NAGIN, MD, JOSHUA G F	ALLEGHENY
NAGLE, MD, ARLINGTON A	BERKS
NAGLE, MD, DEBORAH A	PHILADELPHIA
NAGLE, MD, DOUGLAS B	ERIE
NAGLE, MD, RICHARD W	ERIE
NAGLE, MD, W WILLIAM	DELAWARE
NAGLE, MD, WARREN C	BRADFORD
NAGLE JR, MD, FRANK O	PHILADELPHIA
NAGORSKY, MD, MATTHEW J	PHILADELPHIA
NAGPAL, MD, NARESH C	LYCOMING
NAGY, MD, ROBERT	BERKS
NAIDE, MD, DAVID	PHILADELPHIA
NAIDE, MD, MEYER	PHILADELPHIA
NAIDOFF, MD, MICHAEL A	PHILADELPHIA
NAIDS, MD, RICHARD E	PHILADELPHIA
NAIDU, MD, JAI P	LYCOMING
NAIDU, MD, RAHUL K	WESTMORELAND
NAIK, MD, VAISHALI D	ERIE
NAING, GRACE	STUDENT
NAIR, MD, KRISHNAN K	ERIE
NAIR, MD, MADHUSUDANAN	ALLEGHENY
NAIR, MD, SOMNATH N	PHILADELPHIA
NAIR, MD, V KRISHNAN	SOMERSET
NAIRN JR, MD, JOHN P	ALLEGHENY
NAJI, MD, ALI	PHILADELPHIA
NAJI, MD, MOHAMMED H	LAWRENCE
NAJMI, MD, MOOSA	NORTHAMPTON
NAKHJAVAN, MD, FRED K	PHILADELPHIA
NAKKACHE, MD, VICTOR B	LUZERNE
NALBANTIAN, MD, MICHEL S	PHILADELPHIA
NALEVANKO, MD, ALBERT M	LACKAWANNA
NALIN, MD, DANIEL J	ALLEGHENY
NALIN, MD, DAVID R	PHILADELPHIA
NALLAMOTHU, MD, NASARAIAH	PHILADELPHIA
NALLATHAMBI, MD, HELGA N	BUTLER
NALLATHAMBI, MD, SWAMIKKAN A	BUTLER
NAMEY, MD, JOHN T	MERCER
NAMJOSHI, MD, SHASHIKALA D	PHILADELPHIA
NANCOLLAS, MD, PAUL H	MIFFLIN/JUNIATA
NANGIA, MD, SUSHMA R	ALLEGHENY
NANJUNDASWAMY, MD, HUNASAGATTA C	BEAVER
NANSTEEL JR, MD, JOHN F	DELAWARE
NAPIERKOWSKI, DO, STANLEY A	PHILADELPHIA
NAPLES, MD, JERRY F	BUCKS
NAPOLEON, MD, LOUIS N	ALLEGHENY
NAPOLITANO, MD, JOSEPH D	PHILADELPHIA
NAPPI, MD, DOMINIC F	PHILADELPHIA
NARASIMHAN, MD, SEETHALAKSHMI	ALLEGHENY
NARAYANAN, MD, EDATHIL K	BRADFORD
NARDELLA JR, MD, GUY M	DELAWARE
NARDONE, MD, DONALD T	LYCOMING
NARDUZZI, MD, JOANN V	ALLEGHENY
NARLA, MD, SUDHIR K	ALLEGHENY
NARMI, MD, JEFFREY J	BERKS
NARROW, MD, CHARLES M	BLAIR
NARTATEZ, MD, PEDRO C	CLEARFIELD
NARULA, MD, AMRIT P	SCHUYLKILL
NARUS, MD, VITOLD T	ERIE
NARVAEZ, MD, RICHARD A	PHILADELPHIA
NASCA, MD, THOMAS J	PHILADELPHIA
NASE, MD, DONALD F	BUCKS
NASE, MD, P KENNETH	BERKS
NASEER, MD, KAUKAB	PHILADELPHIA
NASER, MD, MAHMUD A	PHILADELPHIA
NASH, MD, DAVID B	PHILADELPHIA
NASH, MD, DAVID R	ALLEGHENY
NASH, MD, JAMES D	LANCASTER
NASIR, MD, MAHMOOD	NORTHMBRLAND
NASO, MD, FRANCIS	PHILADELPHIA
NASRI, MD, HAMZEH	DELAWARE
NASSAR, MD, JAY P	DAUPHIN
NASSUR, MD, ADNAN K	WESTMORELAND
NAST, JUSTIN B	STUDENT
NAST, MD, MAX S	BUTLER
NAST, MD, PHILIP R	PHILADELPHIA
NATALE, MELISSA A	STUDENT
NATALI, MD, DANIEL E	ALLEGHENY
NATHAN, DAVID L	STUDENT
NATHANSON, MD, AVERY H	ALLEGHENY
NATHANSON, MD, JULIET E	PHILADELPHIA
NATHANSON, MD, MICHAEL S	ALLEGHENY
NATIVIDAD, MD, NITA C	LUZERNE
NATOLI, MD, THOMAS J	MONTGOMERY
NAUGLE, MD, INGRID E	ALLEGHENY
NAULTY, MD, JOHN S	PHILADELPHIA
NAUM, DO, SCOTT M	ALLEGHENY
NAUNCZEK, MICHAEL J	STUDENT
NAUSS, MD, THOMAS J	LUZERNE
NAVARRO, MD, NORMAN F	LEHIGH
NAYAK, KESHAV R	STUDENT
NAYAK, MD, KRISHEN K	ALLEGHENY
NAYAK, MD, NARAYAN P	MCKEAN
NAYAK, MD, NARAYAN T	ALLEGHENY
NAYAK, MD, RAMESH M	BERKS
NAYAK, MD, SATISH R	SOMERSET
NAYAK, MD, SHANTERI U	WESTMORELAND
NAYAR, MD, SUDHA M	WASHINGTON
NAZ, MD, TEHMINA	PHILADELPHIA
NAZAR, MD, JOSE E	BRADFORD
NAZARI, MD, AHMAD	PHILADELPHIA
NAZZARO, MD, RALPH	VENANGO
NEAL, MD, HUNTER S	DELAWARE
NEAL, MD, ROLAND A	ALLEGHENY
NEAL JR, MD, HARRY B	INDIANA
NEALE, MD, JOHN M	INDIANA
NEALIS, MD, HENRY J	MONTGOMERY
NECAS, MD, MICHAEL G	VENANGO
NEDEROSTEK, DOUGLAS F	STUDENT
NEDRESKY, MD, JOSEPH P	ERIE
NEDWICH, MD, ALEXANDER	LEHIGH
NEE JR, MD, MARTIN P	ALLEGHENY
NEEDELL, JAMES E	STUDENT
NEEDLE, MD, MICHAEL N	PHILADELPHIA
NEELEY, MD, STEVEN W	BEAVER
NEELY, MD, EILEEN P	ALLEGHENY
NEFCY, MD, PETER M	CAMBRIA
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NEFF, MD, SAMUEL R	MONTGOMERY
NEFT, MD, BURTON H	ALLEGHENY
NEGREY JR, MD, JOHN N	DELAWARE
NEGRI, MD, ANN M	ALLEGHENY
NEGRIN, MD, EYLIN M	DELAWARE
NEGRINI, MD, BARBARA J	ALLEGHENY
NEGRO, MD, ATTILIO G	WESTMORELAND
NEGRON, MD, ANGEL M	ERIE
NEI, MD, MAROMI	PHILADELPHIA
NEIDERER, DO, PHILIP A	CUMBERLAND
NEIDHARDT, MD, PAUL W	LANCASTER
NEIGH, MD, JOHN L	PHILADELPHIA
NEILL, DO, THOMAS H	NORTHAMPTON
NEILSON, MD, ROBERT N	MONTGOMERY
NEILSON, MD, THOMAS J	ALLEGHENY
NEIMAN, MD, HARVEY L	ALLEGHENY
NEIMAN, MD, LEE M	ALLEGHENY
NEIS, MD, MARISSA C	ERIE
NEISH, MD, CAROL L	ALLEGHENY
NEJMAN, MD, JOSEPH H	MONTGOMERY
NELL-BADRA, MD, ROCIO E	MONTGOMERY
NELLHAUS, MD, KURT M	ALLEGHENY
NELSON, MD, ANDERS P	LACKAWANNA
NELSON, MD, ANNE S	PHILADELPHIA
NELSON, MD, BARRY K	MONTGOMERY
NELSON, MD, EDWARD A	YORK
NELSON, MD, ELEANOR C	PHILADELPHIA
NELSON, MD, FREDRIC P	PHILADELPHIA
NELSON, MD, JAMES E	LUZERNE
NELSON, MD, LEONARD B	PHILADELPHIA
NELSON, MD, MORTIMER T	BUCKS
NELSON, MD, PHILIP K	LYCOMING
NELSON, MD, STEPHEN C	DELAWARE
NELSON, MD, THEODORE C	ALLEGHENY
NELSON, MD, WALDO E	PHILADELPHIA
NELSON JR, MD, HARRY M	MONTGOMERY
NEMANI, MD, PANDHARINATH	WASHINGTON
NEMEC, MD, JOHN E	WESTMORELAND
NEMEZ, MD, ALBERT	PHILADELPHIA
NEMEZ, MD, JACK S	PHILADELPHIA
NEMIROFF, MD, MARK S	BUCKS
NEMIROFF, MD, RICHARD L	PHILADELPHIA
NEMIROVSKY, MD, BORIS	PHILADELPHIA
NEMZOFF, MD, SOL L	MONTGOMERY
NENNI, MD, ROGER D	NORTHAMPTON
NESBITT, MD, ALEXANDER R	LYCOMING
NESBITT, MD, JOHN B	CRAWFORD
NESBITT, MD, RICHARD A	COLUMBIA
NESI, MD, DANIEL A	BUCKS
NESPAR, MD, JAMES A	INDIANA
NESPOLI, MD, ANTHONY M	NORTHMBRLAND
NETTA, MD, DENISE A	YORK
NETTROUR, JOHN F	STUDENT
NETTROUR, MD, LEWIS F	ALLEGHENY
NETTROUR III, MD, W SCOTT	ALLEGHENY
NETTROUR IV, MD, WALTER S	ALLEGHENY
NEUFELD, STEVEN K	STUDENT
NEUHAUSER, DO, JEFFREY H	PHILADELPHIA
NEUMAN, MD, ALAN A	LUZERNE
NEUMAN, DO, PAUL C	BUCKS
NEUMANN, DO, MELISSA A	PHILADELPHIA
NEUMANN, DO, RALPH I	DAUPHIN
NEUREUTER, MD, LOUIS J	LANCASTER
NEUSCHWANDER, MD, DAVID C	ALLEGHENY
NEVILLE, MD, EDWIN C	LACKAWANNA
NEVIN, MD, JANICE E	PHILADELPHIA
NEVINS, DIANA L	STUDENT
NEVULIS, MD, JOHN J	MONTGOMERY
NEVYAS, MD, HERBERT J	PHILADELPHIA
NEVYAS, MD, JOANN Y	MONTGOMERY
NEVYAS-WALLACE, MD, ANITA S	PHILADELPHIA
NEW, BARBRA S	STUDENT
NEWBERG, MD, AARON N	PHILADELPHIA
NEWBERG, MD, ANDREW B	PHILADELPHIA
NEWBROUGH, MD, ROBERT S	PHILADELPHIA
NEWCOMER, MD, DAVID L	LANCASTER
NEWELL, MD, PAUL M	ERIE

NEWFELD, MD, MARK L	ALLEGHENY
NEWKIRK, MD, JOHN D	CENTRE
NEWMAN, MD, ANDREW	PHILADELPHIA
NEWMAN, MD, BENJAMIN E	PHILADELPHIA
NEWMAN, MD, DONALD A	SCHUYLKILL
NEWMAN, MD, FRANK W	DELAWARE
NEWMAN, MD, GARY A	MONTGOMERY
NEWMAN, DO, HARRIS M	MONTGOMERY
NEWMAN, MD, LEROY	PHILADELPHIA
NEWMAN, SETH L	STUDENT
NEWMAN, MD, WILLIAM R	BEDFORD
NEWMAN, MD, WILLIAM T	WESTMORELAND
NEWMAN III, MD, WILLIAM H	LACKAWANNA
NEWMAN JR, MD, CLYDE F	MONTGOMERY
NEWSOM, MD, JOHN H	BUCKS
NEWTON, MD, CHARLES T	LACKAWANNA
NEWTON, MD, E DOUGLAS	ALLEGHENY
NEWTON, MD, REX H	ALLEGHENY
NEY, MD, EUGENE C	ALLEGHENY
NEY, MD, F GREGG	BUTLER
NEYLON, MD, MICHAEL P	ERIE
NGEOW, MD, YIN K	FRANKLIN
NGHIEM, DO, GEORGE T	DELAWARE
NGINYO, MD, JOSPHAT A	CAMBRIA
NGUY, STEVEN T	STUDENT
NGUYEN, MD, BACH V	DELAWARE
NGUYEN, MD, DE	ALLEGHENY
NGUYEN, MD, HONG T	YORK
NGUYEN, MD, KENNETH V	PHILADELPHIA
NGUYEN, MINH D	STUDENT
NGUYEN, MD, MINH Q	NORTHAMPTON
NGUYEN, MD, MINHLY T	LEHIGH
NGUYEN, MD, NGHI V	ALLEGHENY
NGUYEN, MD, NHIEN D	LEBANON
NGUYEN, MD, THACH N	DAUPHIN
NGUYEN, MD, TUONG C	PHILADELPHIA
NIAMI, MD, NEVSI	MONTGOMERY
NIBBELINK, MD, DONALD W	PHILADELPHIA
NICASSIO, MD, ANTHONY	ALLEGHENY
NICASTRO, MD, GENNARO C	PHILADELPHIA
NICHAMIN, MD, LOUIS D	CLARION
NICHINI, MD, FRANCO M	CHESTER
NICHOLAS, MD, ANGELA M	LYCOMING
NICHOLAS, MD, BRADLEY E	YORK
NICHOLAS, MD, GARY G	LEHIGH
NICHOLAS, MD, JAMES L	YORK
NICHOLAS, MD, LESLIE	PHILADELPHIA
NICHOLAS, MD, W CHANNING	CENTRE
NICHOLAS JR, MD, PETER D	BERKS
NICHOLLS, MD, JOAN E	SCHUYLKILL
NICHOLLS, MD, RICHARD H	SCHUYLKILL
NICHOLS, MD, CLAUDE E	DAUPHIN
NICHOLS, MD, DAVID P	JEFFERSON
NICHOLS, MD, DEBRA C	ALLEGHENY
NICHOLS, MD, STEPHEN F	LANCASTER
NICHOLS, MD, WARREN W	MONTGOMERY
NICHOLS, MD, WILLIAM R	ALLEGHENY
NICHOLS JR, MD, TRENT W	YORK
NICHOLSON, MD, JOSEPH T	MONTGOMERY
NICHOLSON JR, MD, WALTER J	YORK
NICKENS, MD, OSWALD J	ALLEGHENY
NICKESON, MD, ROBERT W	ALLEGHENY
NICKISCHER, DO, BRENT M	STUDENT
NICKLAS, MD, DONALD A	CHESTER
NICKLAS, MD, GILBERT L	CLINTON
NICKLES, DO, JULIE P	YORK
NICKOLAS-SWATSKI, MD, KARLA M	MONTGOMERY
NICOLAS, MD, RUDY J	CENTRE
NICOLAU, MARTIN F	STUDENT
NICOLO, MD, ENRICO	ALLEGHENY
NICOLOSI, MD, JOSEPH V	ALLEGHENY
NICOLSON, MD, SUSAN C	PHILADELPHIA
NIKY, MD, NADIA L	PHILADELPHIA
NIDITCH, MD, A SCOTT	LYCOMING
NIEDELMAN, MD, MEYER L	PHILADELPHIA
NIEDERMAYER, MD, GEORGE H	PHILADELPHIA
NIEHLS, MD, BEVERLY J	BERKS
NIELAND, MD, MICHAEL L	ALLEGHENY
NIELAND-FISHER, MD, NANCY S	ALLEGHENY
NIELSEN, MD, R CRAIG	LYCOMING
NIELSEN, MD, ROBERT K	LEBANON
NIELSON, MD, DAVID H	PHILADELPHIA
NIES, MD, GERALD F	WASHINGTON
NIESEN, MD, EMIL T	WAYNE/PIKE
NIETO, MD, VICTOR E	BUTLER
NIEZGODA, MD, PAUL E	LUZERNE
NIGBOROWICZ, MD, RONALD J	ALLEGHENY
NIKOLAIDIS, MD, LAZAROS A	YORK
NIKOULA, MD, JAWDAT A	WESTMORELAND
NIMOITYN, MD, BENJAMIN S	PHILADELPHIA
NIMOITYN, MD, PHILIP	PHILADELPHIA
NINO, MD, RAYMOND F	WESTMORELAND
NISENBAUM, MD, HARVEY L	PHILADELPHIA
NISENBAUM, MD, MARCIA R	ALLEGHENY
NISHIMURA, GREGORY S	STUDENT
NISSIM, MD, KENNETH R	ALLEGHENY
NISSLEY, MD, JAY M	UNION
NISTA, MD, JOSEPH A	ALLEGHENY
NITKA, DO, DONNA M	CLARION
NITSKANSKY, MD, LEA	PHILADELPHIA
NITZBERG, MD, ROBERT S	ALLEGHENY
NIX, MD, COLLIER B	LYCOMING
NIX, MD, ROBERT D	ALLEGHENY
NIZEN, MD, JENNIFER S	PHILADELPHIA
NOAH, MD, JOSEPH	MONTGOMERY
NOBEL, MD, GOLDA R	PHILADELPHIA
NOBEL, MD, HELEN V	ALLEGHENY
NOBEL, MD, JOEL J	PHILADELPHIA
NOBLE, MD, ELLENETTA B	WASHINGTON
NOBLE, MD, JEYASEELAN	BUCKS
NOBLE, MD, S ROSS	BERKS
NOCCHI, DAVID M	STUDENT
NOCERINI, ROBERT J	STUDENT
NOCHE, MD, CESAR N	FAYETTE
NODEN, MD, GEORGE T	ALLEGHENY
NOEL, MD, PAUL A	WESTMORELAND
NOFSINGER, CHARLES C	STUDENT
NOFTZGER, MD, MARTHA R	GREENE
NOLAN, MD, J PHILIP	MONTGOMERY
NOLAN, MD, SEAN	ALLEGHENY
NOLAN, MD, TERESA A	ALLEGHENY
NOLT, MD, JEFFREY S	ADAMS
NOLTE, DO, ROBERT S	DAUPHIN
NONACK, MD, PETER B	DELAWARE
NOONE, MD, JAMES P	BRADFORD
NOONE, MD, R BARRETT	PHILADELPHIA
NOORANI, SHIRIN S N	STUDENT
NOORBAKHSH, MD, HOSSEIN	ALLEGHENY
NORATO, MD, JOSEPH F	DAUPHIN
NORD, MD, D SCOTT	BERKS
NORD, MD, ROLAND E	LAWRENCE
NORDEN, MD, DANIEL K	DELAWARE
NORDENBERG, MD, AARON	DAUPHIN
NORDSTROM, MD, CARLA R	PHILADELPHIA
NORK, MD, EDWARD P	LUZERNE
NORKUS, MD, GREGORY	LYCOMING
NORONHA, MD, ANANDPRAKASH I	DELAWARE
NORRIS, MD, CHARLES M	PHILADELPHIA
NORRIS, MD, DAVID C	ALLEGHENY
NORRIS, MD, JOHN N	MCKEAN
NORRIS, MD, ROBERT B	PHILADELPHIA
NORTHROP, MD, HERBERT L	MONTGOMERY
NORTHRUP, MD, BRUCE E	PHILADELPHIA
NORWOOD, MD, WILLIAM I	PHILADELPHIA
NOSHENY, MD, STANLEY Z	PHILADELPHIA
NOTARO, MD, JOHN	BEAVER
NOTHMANN, MD, BRUCE J	ALLEGHENY
NOTHSTEIN, DO, GARY D	LUZERNE
NOTTE, MD, MICHAEL A	ALLEGHENY
NOTZ, MD, ROBERT G	MONTOUR
NOUD, MD, PATRICK J	CARBON
NOURIAN, MD, ALI A	LACKAWANNA
NOVAK, MD, CHRISTOPHER	NORTHAMPTON
NOVAK, MD, JOSEPH	SOMERSET
NOVAK, MD, JOSEPH F	ALLEGHENY
NOVAK, MD, KEVIN J	ERIE
NOVAKOVIC, MD, RACHEL L	BLAIR
NOVEMBER, MD, STEPHEN R	ALLEGHENY
NOVROSKI, DO, HENRY C	LUZERNE
NOWACKI, MD, STANLEY M	MONTGOMERY
NOWAK, MD, TINA P	ALLEGHENY
NOWAKOWSKI, MD, BEATA B	NORTHAMPTON
NOWOSIWSKY, MD, TARAS	PHILADELPHIA
NSEIR, MD, NAWAF I	WESTMORELAND
NTOSO, MD, MAY-ANGE	PHILADELPHIA
NUCUM, MD, AFRODISIO N	LEBANON
NULL, MD, HARRY M	ALLEGHENY
NULLET, MD, FRANCIS R	ERIE
NUNEZ, MD, DANIELE M	PHILADELPHIA
NUNEZ, MD, HERMES	ALLEGHENY
NUNGESSER, MD, RAYMOND F	COLUMBIA
NURBHAI, MD, MURTAZA E	POTTER
NUSBAUM, MD, MOREYE	PHILADELPHIA
NUSCHKE, MD, JOHN D	BUCKS
NUSSBAUM, MD, ALLEN S	YORK
NUSSBAUM, MD, ARTHUR J	ALLEGHENY
NUSSBAUM, MD, STEVEN J	DELAWARE
NUTHI, MD, UMADEVI	MONTGOMERY
NUTT III, MD, JAMES N	MONTGOMERY
NUTTER, MD, DAVID E	LANCASTER
NUTTING, MD, RON D	BERKS

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O'BANION, MD, KATHLEEN S	PHILADELPHIA
O'BOYLE, MD, JULIANNE J	DAUPHIN
O'BOYLE, DO, LOUIS J	DAUPHIN
O'BRIEN, MD, EDWARD T	ERIE
O'BRIEN, ERIN M	STUDENT
O'BRIEN, MD, GERARD T	ALLEGHENY
O'BRIEN, MD, JAMES J	MONTGOMERY
O'CONNELL, MD, BRENT J	DAUPHIN
O'CONNELL, MD, JAMES P	INDIANA
O'CONNOR, MD, ELLEN M	PHILADELPHIA
O'CONNOR, LYNN M	STUDENT
O'CONNOR, MD, ROBERT D	SCHUYLKILL
O'CONNOR, MD, THOMAS W	LANCASTER
O'DEA, MD, THOMAS P	DELAWARE
O'DONNELL, MD, NANCY J	NORTHAMPTON
O'DONNELL, SEAN M	STUDENT
O'DONNELL, MD, WARD J	MONTGOMERY
O'DOWD, MD, LIZA C	PHILADELPHIA
O'FLYNN, MD, RICHARD P	DELAWARE
O'GRADY, MD, TIMOTHY J	PHILADELPHIA
O'HARA, MD, A EDWARD	PHILADELPHIA
O'HARA, DO, MARY BETH A	LEHIGH
O'HARA JR, MD, JOHN J	CHESTER
O'KEEFE, MD, JULIE A	ALLEGHENY
O'KELLY, MD, PETER P	FAYETTE
O'LEARY, MD, JAMES A	NORTHAMPTON
O'MALLEY, MD, DONALD F	ALLEGHENY
O'MALLEY, MD, ERIN A	PHILADELPHIA
O'MALLEY, MD, JOHN E	CHESTER
O'MALLEY, MD, JOSEPH F	MONTGOMERY
O'MALLEY, MD, KEVIN B	PHILADELPHIA
O'MARA, DO, ELLEN M	YORK
O'NEILL, DO, JOSEPH G	BUCKS
O'NEILL, MD, SHEA A	ALLEGHENY
O'NEILL JR, MD, JAMES A	PHILADELPHIA
O'ROARK, DO, DANIEL M	ALLEGHENY
O'ROURKE, MD, JOHN N	MONTOUR
O'SHEA, MD, JOHN G	CENTRE
OAKES, EVAN M	STUDENT
OBAGI, SUZAN	STUDENT
OBER, MD, SCOTT K	ALLEGHENY
OBERFIELD, MD, WILLIAM J	DELAWARE
OBLEY, MD, DAVID L	ALLEGHENY
OBOYLE, MD, TOMAS A	LACKAWANNA
OBRIEN, MD, JAMES S	UNION
OBRIEN, MD, ROBERT G	ALLEGHENY
OBRIEN, MD, WILLIAM R	PHILADELPHIA
OBRIEN III, MD, FRANK D	LUZERNE
OBRIEN JR, MD, JAMES E	PHILADELPHIA
OBUZ, MD, VEDAT	PHILADELPHIA
OCAMPO, MD, RENATO G	MCKEAN
OCHEN, MD, PAMELA J	LUZERNE
OCHENRIDER, MD, PAUL D	YORK
OCHOA, MD, E RICARDO	ALLEGHENY
OCHOCO-CAVANAUGH, MD, LILLIAN A	ALLEGHENY
OCKRYMIEK, DO, DOUGLAS A	LANCASTER
OCONNELL, MD, C LEONARD	GREENE
OCONNELL, MD, JAMES R	DELAWARE
OCONNOR, MD, JOHN P	ALLEGHENY
OCONNOR, MD, LEO E	CAMBRIA
OCONNOR, MD, MAUREEN E	PHILADELPHIA
OCONNOR, MD, MICHAEL J	PHILADELPHIA
OCONNOR, MD, WILLIAM F	BEAVER
OCONNOR JR, MD, JAMES J	LACKAWANNA
OCONOR, MD, LORRAINE M	PHILADELPHIA
OCONOR JR, MD, G THOMAS	LANCASTER
ODIM, MD, USIM	ALLEGHENY
ODONNELL, MD, CHRIS T	ALLEGHENY
ODONNELL, MD, CHRISTINE S	BUCKS
ODONNELL, MD, GEORGE J	LUZERNE
ODONNELL, MD, WALTER F	ALLEGHENY
ODORICO, MD, JON S	PHILADELPHIA
ODORISIO, MD, LYNNE A	PHILADELPHIA
ODORIZZI, DO, MARK G	LYCOMING
OEHRLE, MD, JOHN S	ALLEGHENY
OELS, MD, HELEN C	MONTGOMERY
OESTERLING JR, MD, EVERETT F	ALLEGHENY
OFFERMAN, MD, JOOP	ALLEGHENY
OFFIT, MD, PAUL A	PHILADELPHIA
OFFNER, MD, THEODORE W	PHILADELPHIA
OGLE, MD, KIM	ALLEGHENY
OGOKE, MD, BENTLEY A	LEHIGH
OGUN, MD, DAVID J	ALLEGHENY
OH, MD, CHANG W	LEBANON
OH, CHIEN C	STUDENT
OH, EUGENE	STUDENT
OH, MD, JANG K	PHILADELPHIA
OH, MD, KOOK-SANG	ALLEGHENY
OH, RICHARD W	STUDENT
OH, MD, SUNG-KYU H	PHILADELPHIA
OH, MD, YONG W	LUZERNE
OHANISSIAN, MD, HANRICK G	DELAWARE
OHARA, MD, KEVIN R	ALLEGHENY
OHENE-FREMPONG, MD, KWAKU	PHILADELPHIA
OHL, MD, BETTINA M G	ADAMS
OHNSMAN, MD, CHRISTINA M	BERKS
OKAGAWA, MD, RICK	PHILADELPHIA
OKEN, MD, DONALD	PHILADELPHIA
OKIN, MD, E MICHAEL	PHILADELPHIA
OKUNSKI, MD, WALTER J	LEHIGH
OLAH, MD, GEORGE W	ALLEGHENY
OLASIN, DO, REGINA F	TIOGA
OLBRICH, MD, CHRISTOPHER D	ALLEGHENY
OLEAGA, MD, JUAN A	PHILADELPHIA
OLEARCHYK, MD, ANDREW S	PHILADELPHIA
OLECK, JOANNE R	STUDENT
OLENGINSKI, DO, MICHAEL A	MONTGOMERY
OLENGINSKI, MD, THOMAS P	LYCOMING
OLEWILER, MD, SCOTT D	BERKS
OLEWILER JR, MD, H NEWTON	NORTHAMPTON
OLIM, MD, DAVE B	MONTGOMERY
OLIN, MD, STEPHEN T	LANCASTER
OLINSKY, MD, STUART M	LYCOMING
OLIVENSTEIN, MD, ALAN E	ALLEGHENY
OLIVER, MD, GLEN L	LEHIGH
OLIVER, MD, JOHN G	NORTHAMPTON
OLIVER, MARK C	STUDENT
OLIVER-SMITH, MD, DAVID R	ALLEGHENY
OLIVES, MD, MANUEL	DAUPHIN
OLIVIERI, MD, SUZANNE P	MONTGOMERY
OLKEN, MD, MARK D	PHILADELPHIA
OLKOWSKI, MD, STEVEN T	YORK
OLLER, MD, SAMUEL	MONTGOMERY
OLNEY, MD, FRANKLIN B	CENTRE
OLSEN, MD, KARL R	ALLEGHENY
OLSEN, MD, KEVIN H	LACKAWANNA
OLSEN, LISA A	STUDENT
OLSHEMSKI, MD, FRANK C	LUZERNE
OLSHIN, MD, IRVING J	PHILADELPHIA
OLSON, MD, JANNE R	YORK
OLSON, MD, MARY K	ALLEGHENY
OLSON, MD, RONALD A	LUZERNE
OMANA, MD, JESS E	BUCKS
ONEAL JR, MD, ALEXANDER H	MONTGOMERY
ONEIL, DO, ROBERT J	ALLEGHENY
ONEILL, MD, HUGH	PHILADELPHIA
ONEILL, MD, JOHN J	DELAWARE
ONG, MD, BIENVENIDO S	LAWRENCE
ONG, MD, GEORGE P	CUMBERLAND
ONG, MD, JIMMY J	ALLEGHENY
ONGSIAKO, DO, ALLEN R	BERKS
ONIFER, MD, THEODORE M	MONTGOMERY
ONOFREY, MD, DAVID	LACKAWANNA
ONQUE, MD, GLORIA C	ALLEGHENY
OPALACK, DO, CHERYL A	DAUPHIN
OPASS, MD, EDWARD S	BUCKS
OPIDA, MD, CICERON L	BLAIR
OPIDA, MD, MARINA	BLAIR
OPLINGER, MD, ARTHUR F	BERKS
OPSASNICK, MD, STEPHEN G	MONTGOMERY
ORAL, MD, ARSINUR	ALLEGHENY
ORALLO JR, MD, BALTAZAR H	LUZERNE
ORAM, MD, ALAN J	COLUMBIA
ORAM, MD, MELVIN	LACKAWANNA
ORANGE, MD, PAUL D	FRANKLIN
ORDENTLICH, MD, ELENA	PHILADELPHIA
ORDINARIO JR, MD, VICENTE R	CRAWFORD
ORDIWAY, MD, M VERNON	ELK/CAMERON
ORDWAY JR, MD, EUGENE E	LEHIGH
OREBAUGH, MD, STEVEN L	ALLEGHENY
ORECCHIA, MD, PAUL M	DAUPHIN
ORELLANA, MD, CHARLES F	PHILADELPHIA
ORIE, MD, JOHN R	ALLEGHENY
ORIE, MD, JUDITH E	ALLEGHENY
ORLAND, MD, STEVEN M	BUCKS
ORLANDO, MD, DAVID C	PHILADELPHIA
ORLANDO, MD, JOSEPH D	LUZERNE
ORLEVITCH, MD, STEPHEN R	PHILADELPHIA
ORMAN, HEATHER L	STUDENT
ORMAN, MD, JACK M	MONTGOMERY
ORMAN, MD, STEVEN K	DAUPHIN
ORNDORF, MD, THOMAS P	FRANKLIN
ORNE, MD, MARTIN T	PHILADELPHIA
ORONS, DO, PHILIP D	ALLEGHENY
ORPHANIDES, MD, TIMOTHY	BUCKS
ORQUIZA, MD, CLODUALDO S	BERKS
ORR, MD, DONALD P	ALLEGHENY
ORR, MD, PAUL L	LEHIGH
ORR JR, MD, ROSS M	NORTHAMPTON
ORRINGER, MD, DAVID	ALLEGHENY
ORRIS, MD, DONALD J	JEFFERSON
ORSINI, MD, MICHAEL A	BEAVER
ORTEGA, MARCOS R	STUDENT
OSBERG, MD, LISA A	DAUPHIN
OSBORN, MD, HAYLER H	MONTGOMERY
OSBORN, DO, VALENTINE M	CUMBERLAND
OSBORNE, MD, DAVID P	MCKEAN
OSCHWALD, MD, CHARLES J	CAMBRIA
OSGOOD, MD, CARROLL P	BLAIR
OSHEKA, MD, WILLIAM	ALLEGHENY
OSIAL JR, MD, THADDEUS A	ALLEGHENY
OSIAS, MD, MARC B	MONTGOMERY
OSKIN, DO, JAMES E	ERIE
OSLICK, MD, THEODORE	PHILADELPHIA
OSMANSKI, MD, STEPHEN J	ALLEGHENY
OSMICK, MD, MARY J	PHILADELPHIA
OSOFSKY, MD, MURRAY V	ALLEGHENY
OSORIO, MD, EMMANUEL P	PHILADELPHIA
OSOWSKI, MD, THAD	WASHINGTON
OST, MD, MARY A	CHESTER
OSTAPOVICZ, MD, DIANA M	PHILADELPHIA
OSTDAHL, MD, ROGER H	DAUPHIN
OSTERHOLM, MD, JEWELL L	PHILADELPHIA
OSTERMAN, MD, A LEE	PHILADELPHIA
OSTFELD, MD, DAVID A	NORTHAMPTON
OSTMAN, MD, ZENAIDA E	DAUPHIN
OSTRUM, MD, BERNARD J	PHILADELPHIA
OTERI, MD, DOMENIC L	DELAWARE
OTERO, MD, JORGE A	LEHIGH
OTOOLE, MD, JAMES D	ALLEGHENY
OTOOLE, MD, THOMAS F	PHILADELPHIA
OTT, MD, CAROL E	PHILADELPHIA
OTTENBERG, MD, DONALD J	PHILADELPHIA
OTTERY, MD, FAITH D	PHILADELPHIA
OTTONELLO, MD, DOMINGO G	ALLEGHENY
OU, MD, KUANG-YU	ALLEGHENY
OUANO, MD, ROMEO C	LUZERNE
OVERBECK, MD, MICHAEL D	MONTGOMERY
OVERFIELD, MD, EDWARD M	ERIE
OVERLY, MD, WYLIE L	WESTMORELAND
OVERTON, MD, MARK H	BEAVER
OWEN, MD, CYNTHIA M	YORK
OWENS, MD, DAVID E	LUZERNE
OWENS, MD, E REESE	ALLEGHENY
OWENS, DO, EDWARD J	CRAWFORD
OWENS, MD, ERIK L	DAUPHIN
OWENS, JEFFREY A	STUDENT
OWENS, MD, JOHN D	YORK
OWENS, MD, JOHN S	PHILADELPHIA
OXMAN, MD, REED S	PHILADELPHIA
OYLER, CYNTHIA E	STUDENT
OYLER, MD, PAUL F	YORK
OZAKI, MD, WAYNE H	ALLEGHENY
OZOLEK, MD, JOHN A	ALLEGHENY

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PACANA, SUSAN M	STUDENT
PACE, MD, CAROLYN B	MONTGOMERY
PACEK, MD, ROBERT F	ARMSTRONG
PACHTMAN, MD, ISADORE	ALLEGHENY
PACIFICO, MD, RONALD L	ALLEGHENY
PACIOTTI, MD, SAMUEL M	MONROE
PACIULLI, MD, RAFFAELE	BERKS
PACKER, MD, JEFFREY E	LANCASTER
PACKER, MD, LESLIE A	MONTOUR
PACKER, MD, STUART H	BUCKS
PACKMAN, MD, BARRY E	PHILADELPHIA
PACKMAN, MD, IRA J	DAUPHIN
PACURARIU, MD, RADU I	LUZERNE
PADALINO, MD, MICHAEL J	VENANGO
PADEN, MD, DRUE R	LUZERNE
PADIN, MD, FREDERICO A	VENANGO
PADIYAR, MD, RAMDAS B	BERKS
PADOLICK, JOSEPH M	STUDENT
PADOLINA, MD, RUBY M	PHILADELPHIA
PADRTA JR, MD, JERRY C	ALLEGHENY
PADULA, MD, ANTHONY M	PHILADELPHIA
PAE, MD, DONG W	WESTMORELAND
PAE, MD, WALTER E	DAUPHIN

PAEZ, MD, EDUARDO J	PHILADELPHIA
PAGAN, MD, PATRICIA	PHILADELPHIA
PAGANA, MD, JOHN P	NORTHMBRLAND
PAGANA, MD, TIMOTHY J	LYCOMING
PAGANA II, MD, CHARLES C	LYCOMING
PAGANO, MD, ROBERT J	ALLEGHENY
PAGANO, MD, TRINA M	LUZERNE
PAGE, MD, ROBERT B	DAUPHIN
PAGE JR, MD, EDWIN H	BEAVER
PAGLIA, MD, JOHN A	MONROE
PAGNANELLI, MD, DAVID M	MONTGOMERY
PAGNIELLO, MD, LUCIA	CRAWFORD
PAI, MD, KOCHIKAR G	ALLEGHENY
PAI, MD, NARENDRA M	MIFFLIN/JUNIATA
PAINTER, MD, MICHAEL J	ALLEGHENY
PAINTER, DO, SUSAN G	WESTMORELAND
PAISLEY, KEVIN J	STUDENT
PAJEK, MD, EMIL M	NORTHAMPTON
PAL, MD, SHIKHA	STUDENT
PALANDJIAN, MD, KHATCHADOUR B	LACKAWANNA
PALANISAMY, MD, SUBRAMANIAM	ALLEGHENY
PALANT, MD, MARINA B	PHILADELPHIA
PALARSKI, MD, JEFFREY D	ALLEGHENY
PALAT, DO, HERMAN W	PHILADELPHIA
PALATKA, MD, ANDREW A	LAWRENCE
PALCHICK, MD, BRYCE A	ALLEGHENY
PALENA, MD, PETER V	DELAWARE
PALETTA, MD, JOHN D	STUDENT
PALILLA, MD, THOMAS F	PHILADELPHIA
PALIN, MD, WILLIAM E	BEDFORD
PALINKAS, MD, ROBERT D	MONTOUR
PALKOVITZ, MD, HARRY P	ALLEGHENY
PALLADINO, MD, DIANE P	PHILADELPHIA
PALLAN, MD, LAURA A	ALLEGHENY
PALLAS, MD, RANDOLPH S	BERKS
PALLEN, MD, DANIEL	LANCASTER
PALLITTO, MD, LORRAINE R	BUCKS
PALLONE, DO, LESLIE T	BEAVER
PALMA, DOUGLAS A	STUDENT
PALMER, MD, ARTHUR H	ALLEGHENY
PALMER, MD, MEADE T	MONROE
PALMER, MD, MICHAEL H	FRANKLIN
PALMER, MD, ROBERT H	PHILADELPHIA
PALMER, DO, TERESA J	ALLEGHENY
PALMER JR, MD, DALE H	CENTRE
PALMER JR, MD, WILLIAM	ALLEGHENY
PALMER JR, MD, WILLIAM E	CAMBRIA
PALMON, MD, FLORENTINO E	PHILADELPHIA
PALOMBO, MD, CHRISTOPHER J	ALLEGHENY
PALONI, MD, LAURIE E	BUCKS
PALUMBO JR, RALPH	STUDENT
PALUS, MD, BERNARD R	ALLEGHENY
PALUSHOCK, MD, SHARON	LACKAWANNA
PALUSO, MD, JOHN R	WASHINGTON
PALYDOWYCZ, MD, SEVERIN B	WAYNE/PIKE
PAN, MD, EDWARD L	BERKS
PANAHANDEH, MD, ABOLHASSAN	ALLEGHENY
PANAHANDEH, MATTHEW R	STUDENT
PANARO, MD, RUDOLPH J	MONTGOMERY
PANAYOTOVA, MD, MARIA L	NORTHAMPTON
PANCHAL, MD, PRAVIN D	ALLEGHENY
PANCOAST, MD, STEPHEN J	LACKAWANNA
PANDELIDIS, MD, K NICHOLAS	YORK
PANDELIDIS, MD, P KIRK	YORK
PANDIT, MD, DEVAYANI I	ALLEGHENY
PANDIT, MD, NIRAJ P	BERKS
PANDIT, MD, RASHMIKANT S	BLAIR
PANDIT, MD, SANTOSH M	ALLEGHENY
PANDOLFI, MD, FRANK J	PHILADELPHIA
PANDYA, NAIMISH B	STUDENT
PANEBIANCO, MD, ANTONIO C	LEHIGH
PANETTIERI, MD, REYNOLD A	PHILADELPHIA
PANGBURN, MD, THOMAS L M	ALLEGHENY
PANICCO, DO, RICHARD J	WASHINGTON
PANIKKAR, MD, ANANDA K	COLUMBIA
PANIS, MD, ROBERTO	PHILADELPHIA
PANTALONE, MD, ALBERT	BEAVER
PANTALONE, MD, ANGELO L	ALLEGHENY
PANTALONE, MD, FRANK A	WESTMORELAND
PANZER, MD, GLENN M	LUZERNE
PANZER, MD, HERMAN M	MONTGOMERY
PAOLINI, MD, MAURO J	BERKS
PAPACONSTANTINOU, VALERIE	STUDENT
PAPAS, MD, SPIRO N	ALLEGHENY
PAPAZIAN, MD, ARA	ALLEGHENY
PAPINCAK, MD, LARRY J	FAYETTE
PAPOLA, MD, JOHN S	LEHIGH
PAPPANO JR, MD, JOSEPH E	MONTGOMERY
PAPPAS, MD, CHARLES E	MONTGOMERY
PAPPAS, MD, MICHAEL T	ALLEGHENY
PARABIA, MD, PERIN F	LACKAWANNA
PARAGAS SR, MD, LAMBERTO S	CENTRE
PARAMESWARIN, MD, R	PHILADELPHIA
PARANJPE, MD, MOHAN K	ALLEGHENY
PARASCANDOLA, MD, SALVATORE A	DAUPHIN
PARASHARA, MD, DEEPAK K	PHILADELPHIA
PARCELLA, MD, PHYLLIS A	BERKS
PARDINE, MD, MARILYN T	WAYNE/PIKE
PAREDES, MD, JUAN C	ALLEGHENY
PARENT JR, MD, FERNAND N	WASHINGTON
PARENTI, DO, DANIEL J	PHILADELPHIA
PARENTI, MD, JOHN M	MONTOUR
PARESO, MD, JAMES D	WASHINGTON
PARIKH, MD, BHARATI K	ALLEGHENY
PARIKH, MD, MUKUL L	DAUPHIN
PARIKH, MD, NEELIMA M	DAUPHIN
PARIKH, MD, SHIRISH N	BERKS
PARISI, MD, ERIKA F	DELAWARE
PARK, MD, CHAN H	PHILADELPHIA
PARK, MD, CHONG H	PHILADELPHIA
PARK, MD, CHONG S	ERIE
PARK, MD, HONG S	CUMBERLAND
PARK, MD, IN-BUM	ALLEGHENY
PARK, MD, JAE O	FRANKLIN
PARK, JEANNE S	STUDENT
PARK, MD, JOSEPH M	INDIANA
PARK, MD, JULIE U	PHILADELPHIA
PARK, MD, MIN H	FAYETTE
PARK, MD, NAE H	DAUPHIN
PARK, MD, NANCY H	ALLEGHENY
PARK, MD, NEIL I H	CAMBRIA
PARK, MD, PAULINE K	PHILADELPHIA
PARK, MD, SANG B	ALLEGHENY
PARK, MD, SUNG H	SCHUYLKILL
PARK, MD, YOUNG W	LYCOMING
PARKER, MD, ALBERT F	CHESTER
PARKER, MD, ANDREW J	MIFFLIN/JUNIATA
PARKER, DONNA J	STUDENT
PARKER, DO, FRANK	CLINTON
PARKER, MD, GERALD A	WESTMORELAND
PARKER, MD, JOHN S	WESTMORELAND
PARKER, MD, STEVEN L	LANCASTER
PARKS, MD, DONALD B	PHILADELPHIA
PARKS, DO, JOSEPH L	INDIANA
PARKS JR, MD, LYTLE R	CENTRE
PARLAVECCHIO, MD, DENNIS S	JEFFERSON
PARLEE, MD, DONALD E	BUCKS
PARLIMENT, MD, JOEL W	LANCASTER
PARMAR, MD, RASIK B	MIFFLIN/JUNIATA
PARMELEE, DO, TONI J H	LUZERNE
PARMET, MD, JONATHAN L	PHILADELPHIA
PARNES, MD, CURT I	MONTGOMERY
PARNES, MD, HERBERT M	DAUPHIN
PARONISH, MD, CHRISTOPHER B	WESTMORELAND
PARR, MD, JUSTIN L	PHILADELPHIA
PARRIS, CORDEL Y	STUDENT
PARRIS, MD, TED M	PHILADELPHIA
PARRY, MD, CAROLYN E	PHILADELPHIA
PARRY, MD, H FRAZER	PHILADELPHIA
PARRY, MD, JOHN K	CENTRE
PARRY, MD, JOHN S	MIFFLIN/JUNIATA
PARRY, MD, PETER	DELAWARE
PARRY, MD, RHINARD D	NORTHAMPTON
PARSICK, MD, DANIEL P	LACKAWANNA
PARTEZANA, MD, JANETTE S	ALLEGHENY
PARTRIDGE, MD, ROBERT A	DELAWARE
PARVA, MD, GHASEM	ALLEGHENY
PARVISKHAN, DO, LISA F	MONTGOMERY
PASCAL, MD, HAROLD J	MONROE
PASCAL, MD, JOSEPH	LEHIGH
PASCUA, MD, ALEXANDER V	BEAVER
PASCUAL, MD, GENEROSO S	ALLEGHENY
PASCUCCI, MD, STEPHEN E	LACKAWANNA
PASCUCCI, MD, STEPHEN E	LACKAWANNA
PASDAR, MD, HOMAYOON	DELAWARE
PASH, MD, CHRISTOPHER A	ALLEGHENY
PASHMAN, MD, DAVID R	PHILADELPHIA
PASKIN, MD, DAVID L	PHILADELPHIA
PASKO, RITA N	STUDENT
PASQUALICCHIO, DO, GARY E	ERIE
PASQUARIELLO, MD, PATRICK	PHILADELPHIA
PASQUARIELLO, MD, PATRICK S	PHILADELPHIA
PASQUARIELLO, MD, RICK D	STUDENT
PASSERO, MD, FRANK C	DELAWARE
PASTOR, MD, JAMES A	LEBANON
PASTORE, MD, GAETANO N	PHILADELPHIA
PASTORE, MD, TIMOTHY P	PHILADELPHIA
PASTUSZKO, PETER	STUDENT
PATADIA, MD, CHANDRAKANT	BERKS
PATAKI, MD, RICHARD S	WASHINGTON
PATALINGHUG JR, MD, PASCUAL N	FRANKLIN
PATANKAR, MD, JAYANT L	ELK/CAMERON
PATCHEFSKY, MD, ARTHUR S	PHILADELPHIA
PATCHEN JR, MD, PATRICK N	ALLEGHENY
PATEL, MD, ARUN R	BLAIR
PATEL, MD, ASHVINBHAI D	ALLEGHENY
PATEL, MD, ASIT P	LUZERNE
PATEL, MD, BAKULESH D	MONTOUR
PATEL, MD, BHARAT K	LACKAWANNA
PATEL, MD, BHUPENDRA R	LACKAWANNA
PATEL, MD, BHUPENDRA R	SUSQUEHANNA
PATEL, MD, BIPIN M	LACKAWANNA
PATEL, MD, DEEPAK V	PHILADELPHIA
PATEL, MD, GAUTAM P	ALLEGHENY
PATEL, MD, HARISH K	ALLEGHENY
PATEL, MD, HARSHAD R	LYCOMING
PATEL, MD, HARSHADKUMAR B	LANCASTER
PATEL, MD, HITENDRA R	ALLEGHENY
PATEL, MD, HITESH K	BUCKS
PATEL, MD, JAGDISH D	CAMBRIA
PATEL, MD, JANMEJAY J	PHILADELPHIA
PATEL, MD, JASMINE K	PHILADELPHIA
PATEL, MD, JAYANTILAL R	BUCKS
PATEL, MD, JAYKUMAR	BUCKS
PATEL, MD, JIVANLAL M	CLARION
PATEL, MD, KANCHANLAL S	LAWRENCE
PATEL, MD, KANTILAL C	ERIE
PATEL, MD, KAUSHIK J	BEDFORD
PATEL, MD, KISHOR D	BLAIR
PATEL, MD, MADHUKAR R	LEBANON
PATEL, MD, MAHESH N	BUCKS
PATEL, MD, MANOJBHAI P	WASHINGTON
PATEL, MD, MANOJKUMAR R	BEAVER
PATEL, MD, MANUBHAI R	PHILADELPHIA
PATEL, MD, MINA G	ALLEGHENY
PATEL, MD, MOHAN M	WESTMORELAND
PATEL, MD, MUKESH A	DELAWARE
PATEL, MD, NAINESH M	MONTGOMERY
PATEL, MD, NARENDRA K	PHILADELPHIA
PATEL, MD, NARESH G	ALLEGHENY
PATEL, MD, PRABHA H	DELAWARE
PATEL, MD, PRAVINCHANDRA K	SUSQUEHANNA
PATEL, MD, PURSHOTTAM N	NORTHMBRLAND
PATEL, MD, RAHUL A	MONTGOMERY
PATEL, MD, RAJ J	LYCOMING
PATEL, MD, RAJESH I	STUDENT
PATEL, MD, RAJIV R	ALLEGHENY
PATEL, MD, RAMESH C	LACKAWANNA
PATEL, MD, RASILA P	UNION
PATEL, MD, RITA M	ALLEGHENY
PATEL, MD, SANJAY D	MONTGOMERY
PATEL, SANTOSH C	STUDENT
PATEL, SAYJAL J	STUDENT
PATEL, MD, SHAILESH D	MONTGOMERY
PATEL, MD, SHASHIKANT B	DAUPHIN
PATEL, SHERAL S	STUDENT
PATEL, STEPHANIE	STUDENT
PATEL, MD, SUBODH G	FAYETTE
PATEL, MD, SUMAN A	LACKAWANNA
PATEL, MD, VINOD M	ERIE
PATEL, MD, VRINDA P	BERKS
PATEL, MD, YASHVANTKUMAR S	DELAWARE
PATERNITI, MD, SAMUEL F	LEBANON
PATERSON, MD, KIMBERLY K	DELAWARE
PATHAK, MD, RAJANI K	JEFFERSON
PATHEJA, MD, JOTINDER K	WESTMORELAND
PATHROFF, MD, ROBERT	MONTGOMERY
PATITSAS, MD, CHRISTOPHER J	HUNTINGDON
PATNAIK, MD, RAMPRASAD	PHILADELPHIA
PATNAM, MD, SRIDHAR V	FAYETTE
PATRIARCO, DO, MICHAEL S	LEHIGH
PATRICIO, MD, ALEJANDRO M	FAYETTE
PATRICK, MD, DAVID B	BEAVER
PATRICK, MD, GREGORY B	ALLEGHENY
PATRICK, MD, MICHAEL A	NORTHAMPTON
PATRIZI JR, MD, JAMES D	ALLEGHENY
PATTANAYAK, MD, MINATI	BUCKS
PATTERNAC, MD, STEPHEN T	ALLEGHENY
PATTERSON, MD, CHRIS	DELAWARE
PATTERSON, MD, CHRISTOPHER J	FAYETTE
PATTERSON, MD, JOHN R	PHILADELPHIA
PATTERSON, MD, JOHN W	NORTHAMPTON
PATTERSON, MD, LELAND F	DAUPHIN
PATTERSON, MD, LEWIS T	DAUPHIN
PATTERSON, MD, RICHARD J	DAUPHIN
PATTERSON JR, MD, ARTHUR J	GREENE
PATTON, MD, ANNA M	ALLEGHENY
PATTON, MD, CARLA S	BUCKS
PATTON, MD, GEORGE D	ALLEGHENY
PATTON, MD, MARY L	DELAWARE
PATUKAS, MD, PETER C	CHESTER
PATZ, MD, MARY K	ALLEGHENY
PAUL, MD, ALBERT J	PHILADELPHIA
PAUL, MD, ALVIN J	MONTGOMERY
PAUL, MD, BORIS	MONROE
PAUL, MD, CHAMPA L	BUCKS
PAUL, MD, GERSON S	PHILADELPHIA
PAUL, MD, JAY	BUTLER
PAUL, MD, LEENA	BERKS
PAUL, MD, PHYLLIS O	PHILADELPHIA
PAUL, MD, RICHARD	ALLEGHENY
PAUL, MD, RONALD L	YORK
PAULEY, MD, LOIS P	BUCKS
PAULIN, MD, MITCHELL H	CHESTER
PAULISH, DO, JOHN W	LACKAWANNA
PAULMAN, MD, SCOTT	PHILADELPHIA
PAULOWSKI, MD, JOHN J	ALLEGHENY
PAUTLER, MD, STANISLAV	ALLEGHENY
PAVILACK, MD, MARK A	LANCASTER
PAVLAK, MD, ROBERT J	ALLEGHENY
PAVLIC, MD, GEORGE J	ALLEGHENY
PAVLIDES, MD, CONSTANTINOS A	PHILADELPHIA
PAVLIS, MD, ROBERT J	ALLEGHENY
PAVSEK, MD, EDWARD J	ALLEGHENY
PAVUK, MD, DANIEL J	LACKAWANNA
PAWAR, MD, SURENDRA V	ALLEGHENY
PAWELSKI, MD, LISA A	ALLEGHENY
PAWELSKI, MD, RICHARD J	DAUPHIN
PAWLOSKY, MD, FRANK X	ALLEGHENY
PAWLOWSKI, MD, NICHOLAS A	PHILADELPHIA
PAWLOWSKY, DO, MICHAEL	MONTGOMERY
PAWLUSH, MD, DAVID G	DAUPHIN
PAXSON, DO, STEPHEN G	MERCER
PAYAN, MD, HUSHANG M	ALLEGHENY
PAYER, MD, JEAN M	BERKS
PAYHA, MD, RICHARD E	GREENE
PAYLOR, MD, SHAUNA M	LANCASTER
PAYNE, MD, VIRGINIA L	NORTHMBRLAND
PAZ, MD, HAROLD L	PHILADELPHIA
PAZMINO, MD, ROY R	BLAIR
PEACOCK, MD, THOMAS E	NORTHAMPTON
PEAIRS, MD, RANDALL R	LACKAWANNA
PEAL, MD, STANLEY	ALLEGHENY
PEARAH, MD, J DAVID	BERKS
PEARCE, MD, STEVEN R	YORK
PEARD, MD, ROBERT J	ALLEGHENY
PEARLSTINE, MD, BEATRICE	PHILADELPHIA
PEARMAN, MD, TREVOR J	LANCASTER
PEARSON, MD, JUNE A	MONROE
PEARSON, MD, THOMAS O	MIFFLIN/JUNIATA
PEARSON JR, MD, ROBERT E	DAUPHIN
PEART, MD, RAYMOND E	LANCASTER
PEASE, MD, FRED	CLEARFIELD
PEASE, MD, WILLIAM E	DAUPHIN
PECARSKY, JASON T	STUDENT
PECHIN, MD, SERGIUS P	DELAWARE
PECHSTEIN, MD, GEORGE R	MONTGOMERY
PECHT, MD, KARL R	CLINTON
PECK, ERIC A	STUDENT
PECK, MD, WILLIAM J	LYCOMING
PECMAN, MD, JOANNA	ALLEGHENY
PECORA, MD, MICHAEL J	ALLEGHENY
PECORELLA, WENDY A	STUDENT
PEER, MD, MEETA D	PHILADELPHIA
PEFF, MD, THOMAS C	PHILADELPHIA
PEGGS, MD, MICHAEL A	PHILADELPHIA
PEGUERO, MD, O ALBERTO	LUZERNE
PEIKES, MD, IRWIN L	MONTGOMERY
PEIMER, MD, MICHAEL E	DELAWARE
PEIRSOL, MD, BETTY L	ALLEGHENY
PELCZAR, MD, EUGENE W	LUZERNE
PELEKANOS, MD, MICHAEL J	ALLEGHENY
PELENSKY, MD, JEANNE M	PHILADELPHIA
PELIAS, MD, ANASTASIOS	PHILADELPHIA
PELICCI, MD, LEROY J	LACKAWANNA
PELKOFER, MD, CLETUS G	ALLEGHENY
PELLECCHIA, MD, DENNIS J	BERKS
PELLECCHIA, MD, PATRICK E	PHILADELPHIA
PELLEGRINI, MD, RONALD V	ALLEGHENY
PELLEGRINI, MD, VINCENT A	BERKS
PELLEGRINI JR, MD, VINCENT D	DAUPHIN
PELLEGRINO, MD, LOUIS	PHILADELPHIA
PELLITTERI, DO, PHILLIP K	MONTOUR
PELLIZZARI, MD, RINALDO G	ERIE
PELSZYNSKI, MD, EUGENE E	PHILADELPHIA
PEMBERTON, MD, CLIFFORD H	MONTGOMERY
PENABAD, MD, JESUS L	PHILADELPHIA
PENATER, MD, FRANK R	CARBON
PENCE, MD, ROBERT P	DAUPHIN
PENDRAK, DO, INNA S	MONTGOMERY
PENETAR, DO, BARBARA C	MONTOUR
PENETAR, DO, MARTIN C	LACKAWANNA
PENG, ALBERT	STUDENT
PENKROT, MD, RONALD J	ALLEGHENY
PENMAN, MD, WILLIAM R	CHESTER
PENNE, MD, ROBERT B	PHILADELPHIA
PENNELL, MD, REBECCA G	LANCASTER
PENNER, GARY E	STUDENT
PENNEYS, MD, EDITH T	PHILADELPHIA
PENNINGTON, MD, NEIL D	CHESTER
PENNOCK, MD, JOHN L	DAUPHIN
PENNOCK, MD, RONALD S	PHILADELPHIA
PENROD, MD, LOUIS E	ALLEGHENY
PENSA, EDWARD A	STUDENT
PENTA, MD, JOHN M	BERKS
PENTEL, MD, MARY TRINH	STUDENT
PENUGONDA, MD, DWARAKI B	LUZERNE
PENUGONDA, MD, HARAGOPAL S	LUZERNE
PEOPLES, MD, ALDEN G	YORK
PEPE, MD, PETER F	CENTRE
PEPICELLO, MD, JAMES A	ERIE
PEPPELMAN JR, DO, WALTER C	DAUPHIN
PEPPER, MD, L DOUGLAS	ALLEGHENY
PEPPERMAN, MD, LARUE E	LYCOMING
PERALTA, MD, JUAN O	NORTHMBRLAND
PERALTA IV, MD, FRANCISCO J G	ALLEGHENY
PERCH, MD, GERALD A	MONTGOMERY
PERCH, MD, ROBERT B	MONTGOMERY
PEREIRA, MD, GILBERTO R	PHILADELPHIA
PERER, MD, WILLIAM A	ALLEGHENY
PERERA, MD, L WIMAL	MONTGOMERY
PEREZ, MD, ANAMARIA	BUCKS
PEREZ, MD, GODOFREDO B	FAYETTE
PEREZ, MD, HORACIO A	ALLEGHENY
PEREZ, DO, RAYMOND J	MONTGOMERY
PEREZ, MD, RUBEN	LEBANON
PEREZ-AQUINO, MD, ERLINDA B	FAYETTE
PEREZ-SCHWARTZ, MD, LUZ	PHILADELPHIA
PERFETT, MD, ALFRED A	MERCER
PERILLO, MD, RUTHANN	PHILADELPHIA
PERILSTEIN, MD, MICHAEL D	BERKS
PERKEL, MD, ROBERT L	PHILADELPHIA
PERKINS, MD, JEFFREY C	PHILADELPHIA
PERKINS, MD, PHILIP G	BERKS
PERLMAN, MD, ABRAHAM	PHILADELPHIA
PERLMAN, MD, HERBERT C	CUMBERLAND
PERLMUTTER, DAVID M	STUDENT
PERLMUTTER, MD, GORDON S	BERKS
PERLSTEIN, MD, SAMUEL M	PHILADELPHIA
PERNA, MD, FRANCIS X	DAUPHIN
PEROUTKA, MD, KATHRYN	DAUPHIN
PERRI, MD, FRANCIS R	ALLEGHENY
PERRI, MD, JOHN A	ALLEGHENY
PERRIGE, MD, WILLIAM M	NORTHMBRLAND
PERRIN, MD, RONALD L	ALLEGHENY
PERRONE, MD, FRANK F R	FAYETTE
PERROTTO, MD, JUDITH A	LEBANON
PERROTTO, MD, SANTLE L	PHILADELPHIA
PERRY, MD, ANTHONY M	LACKAWANNA
PERRY, MD, LEE C	BEAVER
PERRY, MD, RUTH E	PHILADELPHIA
PERRYMAN, MD, CHARLES A	ALLEGHENY
PERRYMAN, MD, CHARLES R	ALLEGHENY
PERSHING, MD, HUGH S	BUCKS
PERSIC JR, MD, LOUIS A	CENTRE
PERSIN, DO, GEORGE A	ALLEGHENY
PERSING, MD, JOHN H	UNION
PESKE, MD, EDGAR D	WESTMORELAND

PESSOLANO, MD, CARL J	ALLEGHENY
PESSOLANO, MD, FRANCIS X	SOMERSET
PETERNEL, MD, WAYNE W	ALLEGHENY
PETERS, DO, BRUCE W	PHILADELPHIA
PETERS, MD, CHARLES D	LEHIGH
PETERS, MD, JEROME A	WESTMORELAND
PETERS, MELISSA L	STUDENT
PETERS, MD, MICHAEL	BUCKS
PETERS, MD, RICHARD A	WARREN
PETERS, MD, STANLEY F	BUCKS
PETERS, MD, TODD W	PHILADELPHIA
PETERS, MD, VAUGHAN	ALLEGHENY
PETERS, MD, WALTER K	NORTHAMPTON
PETERS III, MD, ROBERT H	SCHUYLKILL
PETERS JR, MD, ROBERT H	LUZERNE
PETERSOHN, MD, J RANDOLPH	MONTGOMERY
PETERSON, MD, ALISON	ALLEGHENY
PETERSON, MD, ARTHUR L	MONTGOMERY
PETERSON, MD, DONALD D	PHILADELPHIA
PETERSON, MD, JUDITH R	PHILADELPHIA
PETERSON, MD, KARL R	BRADFORD
PETERSON, DO, MICHAEL T	WAYNE/PIKE
PETERSON, MD, ROGER D	LANCASTER
PETERSON JR, MD, CHARLES B	LANCASTER
PETERSON JR, MD, JAY B	WESTMORELAND
PETICCA, MD, BENJAMIN B	ALLEGHENY
PETILLA, MD, MARIANO E	ALLEGHENY
PETKUS, MD, JOHN A	WAYNE/PIKE
PETRAGLIA, MD, ANGELO A	ALLEGHENY
PETRAGLIA, MD, PAUL	ALLEGHENY
PETRAGLIA, DO, VINCENT F	ALLEGHENY
PETRASEK, MD, E BRIAN	LEHIGH
PETRAUSKI, MD, GARY T	BUCKS
PETRE JR, MD, JOHN H	ERIE
PETRELLA, MD, RICHARD W	ERIE
PETRIDES, MD, ANASTASIA B	DELAWARE
PETRO, MD, DIMITRI M	WASHINGTON
PETRONE, MD, LOUIS R	PHILADELPHIA
PETROWSKY, MD, DEBORAH	PHILADELPHIA
PETRUCCELLI, MD, NICHOLAS D	NORTHAMPTON
PETRUCCI, MD, WILLIAM G	PHILADELPHIA
PETT JR, MD, STEPHEN D	ERIE
PETTAPIECE JR, MD, MILTON C	ALLEGHENY
PETTERSON, MD, ERIC	SCHUYLKILL
PETTINATO, MD, SALVATORE R	LACKAWANNA
PETTINELLI, DO, FRANK P	PHILADELPHIA
PETTIT, MD, HORACE	PHILADELPHIA
PETTIT, MD, MARY D	PHILADELPHIA
PETURSSON, MD, SIGURDUR R	ALLEGHENY
PETZ, MD, COLIN J	LEHIGH
PETZ, DO, DARRELL W	ALLEGHENY
PEZZI, MD, PIO J	MONTGOMERY
PEZZI, MD, THOMAS A	PHILADELPHIA
PEZZONE, MD, MICHAEL A	ALLEGHENY
PEZZUTI, MD, JOHN E	DAUPHIN
PFAEFFLE, MD, HUGO H	ALLEGHENY
PFEFFER, DO, SCOTT H	PHILADELPHIA
PFEFFER, MD, WILLIAM H	PHILADELPHIA
PFEFFER, MD, WILLIAM H	YORK
PFEIL, MD, RUSSELL W	LYCOMING
PFISTER, MD, JOHN A	MONTGOMERY
PFOFF, MD, ROBERT M	ALLEGHENY
PFOHL, MD, DAVID N	PHILADELPHIA
PFRIMMER, MD, WAYNE J	ALLEGHENY
PFROMMER, MD, JAMES H	BUCKS
PFROMMER, MD, JAMES M	PHILADELPHIA
PHADKE, MD, YESHWANT G	INDIANA
PHAM, MD, AN H	MONTGOMERY
PHAM, PAUL P	STUDENT
PHAN, MD, NGOC AN	PHILADELPHIA
PHANSE, MD, KALYANI M	WASHINGTON
PHANSE, MD, MOHAN S	ALLEGHENY
PHARR, MD, WILLIAM F	MONTOUR
PHATAK, MD, MEENA V	MONTGOMERY
PHEASANT, MD, THOMAS R	DAUPHIN
PHELAN, MD, GERALD R	MONTGOMERY
PHELAN, MD, WILLIAM J	LEHIGH
PHELAN, MD, WILLIAM J	CUMBERLAND
PHELPS, MD, WILLIAM R	ERIE
PHIAMBOLIS, MD, THOMAS P	MONTGOMERY
PHILBIN, MD, JOSEPH F	LACKAWANNA
PHILLIPS, MD, CHRISTINE	TIOGA
PHILLIPS, MD, EMILIA	BEAVER
PHILLIPS, MD, HOWARD T	ALLEGHENY
PHILLIPS, MD, JANE G	ALLEGHENY
PHILLIPS, MD, JOHN C	ALLEGHENY
PHILLIPS, MD, JOHN G	ALLEGHENY
PHILLIPS, MD, PAUL F	DAUPHIN
PHILLIPS, MD, PETER C	PHILADELPHIA
PHILLIPS, MD, R WAYNE	YORK
PHILLIPS, MD, SPENCER D	LANCASTER
PHILLIPS, MD, THEODORE G	LEHIGH
PHILLIPS, MD, VERNON R	DAUPHIN
PHILLIPS, MD, WILLIAM A	PHILADELPHIA
PHILLIPS, WILLIAM H	STUDENT
PHILLIPS, MD, WILLIAM W	ALLEGHENY
PHILLIPS III, MD, CHESTER A	ALLEGHENY
PHILLIPS JR, MD, CHESTER A	ALLEGHENY
PHITAYAKORN, MD, CHET	ALLEGHENY
PHOOKAN, MD, GAUTAM	DAUPHIN
PIASIO, MD, MARK A	CLEARFIELD
PIATNEK-LEUNISSEN, MD, DOROTHY A	DELAWARE
PIATT, CLARKE U	STUDENT
PIATT III, MD, JOHN E	CENTRE
PICA, MD, JAMES E	WESTMORELAND
PICARIELLO, MD, MICHAEL A	CHESTER
PICCHIO, MD, LUCIANO A	CUMBERLAND
PICCINI, MD, PAUL A	DAUPHIN
PICCOLI, MD, DAVID A	PHILADELPHIA
PICCONE, DO, BRUCE R	PHILADELPHIA
PICCONE, MD, CLAUDIA R	ALLEGHENY
PICCUTA, MD, MICHAEL J	LYCOMING
PICERNO, NICOLETTE A	STUDENT
PICK, MD, ERNEST J	PHILADELPHIA
PICKAR, MD, JAMES H	DELAWARE
PICKENS, MD, PETER V	MONTGOMERY
PICKERILL, MD, ROBERT G	CAMBRIA
PICKERING, MD, HAROLD C	PHILADELPHIA
PIECHOTA, MD, DARREN F	PHILADELPHIA
PIEGARI, MD, GUY N	BERKS
PIEGL, MD, AGNES E	CAMBRIA
PIEPGRASS, MD, WILLIAM C	LANCASTER
PIERCE, GREG	STUDENT
PIERCE, MD, WILLIAM S	DAUPHIN
PIERCE III, MD, JAMES B	MONTGOMERY
PIERCE JR, MD, VINCENT E	PHILADELPHIA
PIERDON, MD, STEVEN B	SCHUYLKILL
PIERETTI, DO, MARTIN O	PHILADELPHIA
PIEROTTI, MD, RICHARD J	MONTGOMERY
PIEROTTI III, MD, ALDINO L	ALLEGHENY
PIERRI, MD, JOSEPH N	ALLEGHENY
PIERSON, MD, STEVEN B	BUCKS
PIETRAGALLO, MD, LOUIS D	ALLEGHENY
PIFALO, MD, W BRADLEY	ALLEGHENY
PIFER, MD, GERALD W	ALLEGHENY
PIGEON, RAYMOND G	STUDENT
PIGOZZI, MD, WILLIAM N	ALLEGHENY
PIKE, MD, ANNE H	PHILADELPHIA
PIKE, MD, DEBRA S	BLAIR
PILCHMAN, MD, JEFFREY M	PHILADELPHIA
PILEGGI, MD, CECILE M	DELAWARE
PILEVSKY, MD, NICOLE D	PHILADELPHIA
PILEWSKI, MD, JOSEPH M	PHILADELPHIA
PILEWSKI, MD, ROBERT M	VENANGO
PILGRAM, MD, PHILIP A	CLEARFIELD
PILKINGTON, MD, BRYAN G	LEBANON
PILLA, MD, MICHAEL A	STUDENT
PILLAI, MD, PUSHKALAI R	ALLEGHENY
PINK, MD, STUART B	DAUPHIN
PINKERTON, DO, RICHARD A	INDIANA
PINNA, MD, ANTONIO D	ALLEGHENY
PINSK, MD, JEFFREY H	DELAWARE
PINSKI, MD, GABRIEL	PHILADELPHIA
PINSON, MD, THOMAS B	STUDENT
PINTO, MD, THOMAS B	ALLEGHENY
PION, DO, JOSEPH A	CUMBERLAND
PIOTROWSKA, MD, LUCY B	MONTGOMERY
PIRAINO, MD, ANTHONY J	DELAWARE
PIRRELLO JR, MD, ANTHONY M	BUTLER
PIRRIS, MD, JOHN	WASHINGTON
PIRWANI, MD, NABEEL	PHILADELPHIA
PISANI, MARGARET A	STUDENT
PISANO, MD, JAMES J	CAMBRIA
PISH, MD, RICHARD J	FAYETTE
PISTONE, MD, DANIEL N	ALLEGHENY
PISTONE, MD, GREGORY A	PHILADELPHIA
PISULA JR, MD, VINCENT P	ADAMS
PISZCZEK, MD, JOSEPH E	LUZERNE
PITCAVAGE, MD, JAMES G	ALLEGHENY
PITCHOK, MD, CARISSA L	STUDENT
PITKOW, MD, RONALD B	BUCKS
PITTENGER, MD, MARY A	PHILADELPHIA
PITTENGER, MD, REX A	ALLEGHENY
PITTS, MD, WILLIAM H	ARMSTRONG
PITUCH, DANIEL W	STUDENT
PITYK JR, MD, PETER E	LEBANON
PIWOZ, MD, SEYMOUR	PHILADELPHIA
PIZANO, MD, LOUIS R	STUDENT
PIZZANO, MD, JOSEPH A	MONTGOMERY
PIZZI, MD, WILSON B	WASHINGTON
PIZZICA, DO, ALBERT L	PHILADELPHIA
PIZZIKETTI, MD, ROBERT J	MONTGOMERY
PIZZINI, MD, MARK-ALAN D	STUDENT
PIZZUTILLO, MD, PETER D	PHILADELPHIA
PLACCI, MD, CARLOS A	ALLEGHENY
PLACE, MD, ELMER R	LEBANON
PLAGATA, MD, EDITH M	DELAWARE
PLANO, DO, VINCENT F	NORTHAMPTON
PLANTE, MD, SABRINA K	LACKAWANNA
PLASTER, MD, MARK L	PHILADELPHIA
PLASTINO, MD, JOHN E	LANCASTER
PLATKO JR, MD, WILLIAM P	ALLEGHENY
PLATT, MD, BENJAMIN B	SCHUYLKILL
PLATT, MD, HOWARD A	LACKAWANNA
PLATT, MD, RUTH M	PHILADELPHIA
PLATTO, MD, MICHAEL J	WASHINGTON
PLEIER, MD, JENNIFER M	MONTGOMERY
PLESS, MD, PETER R	CRAWFORD
PLISKIN, MD, MARK	MONROE
PLOCK, MD, GREGORY L	PHILADELPHIA
PLODKOWSKI, MD, RAYMOND A	STUDENT
PLOTKIN, MD, JEFFREY S	ALLEGHENY
PLOTNICK, MD, MICHAEL I	DELAWARE
PLOURDE, MD, PAUL V	LANCASTER
PLUCINSKY, MD, FRANCIS C	BERKS
PLUMB, MD, JAMES D	PHILADELPHIA
PLUMMER, MD, LLOYD G	WESTMORELAND
PLUMMER III, MD, WILLIAM	CHESTER
PLUNDO, DO, GARY P	WESTMORELAND
PLUNDO, DO, LARRY J	WESTMORELAND
PLUNKETT, MD, FRANCIS X	ALLEGHENY
PLUTNICKI, MD, RONALD S	LANCASTER
PLYMYER, MD, RAY E	BERKS
POBER, MD, HYMEN A	ALLEGHENY
POBER, MD, IREN J	ALLEGHENY
POBER, MD, KENNETH A	INDIANA
POBER, MD, NEIL J	PHILADELPHIA
POCHAPIN, MD, SHERMAN W	ALLEGHENY
POCHCIAL, MD, KAJETAN M	NORTHAMPTON
PODELL, MD, MORRIS J	PHILADELPHIA
PODOLSKY, MD, ELLEN A	PHILADELPHIA
PODOLSKY, DO, JOEL	BERKS
PODOLSKY, MD, LEO A	CHESTER
PODRASKY, MD, DAVID F	BUCKS
PODRAZIK, MD, META L	PHILADELPHIA
PODUFAL, DO, EDWARD	ERIE
POEHAILOS, MD, KAREN D	LEBANON
POGGI, DO, ALFRED J	SOMERSET
POHL, MD, CHARLES E	LANCASTER
POJE, MD, CHRISTOPHER P	PHILADELPHIA
POKORNEY, MD, BRUCE H	LANCASTER
POKORNEY, MD, DALE R	MERCER
POLACHECK JR, MD, WILLIAM J	DAUPHIN
POLAKOFF II, MD, PEDRO	PHILADELPHIA
POLAM, MD, CHANDRA R	ALLEGHENY
POLAN, MD, SIMON	PHILADELPHIA
POLASHENSKI, DO, EDWARD S	LUZERNE
POLES, DO, GWENDOLYN A	DAUPHIN
POLEY JR, MD, GERALD E	MONTGOMERY
POLIDORA, MD, FRANK C	LUZERNE
POLIDORA, MD, JOSEPH J	ALLEGHENY
POLIN, MD, DAVID G	LANCASTER
POLIN, MD, EDWARD B	PHILADELPHIA
POLIN, MD, RICHARD A	PHILADELPHIA
POLINER, MD, HIME S	NORTHAMPTON
POLINSKI, MD, LEONARD J	ALLEGHENY
POLINTAN, MD, RODOLFO S	CLEARFIELD
POLIS, MD, MARK J	LYCOMING
POLISHOOK, MD, ROBERT D	PHILADELPHIA
POLITO, MD, JOSEPH R	CAMBRIA
POLITZER, MD, FRANK E	BERKS
POLK, MD, LEWIS D	PHILADELPHIA
POLK, MD, MIRIAM R	DAUPHIN
POLL, MD, DAVID S	PHILADELPHIA
POLLACK, MD, BARRY J	NORTHAMPTON
POLLACK, MD, DEBRA A	PHILADELPHIA
POLLACK, MD, DOROTHY J	ALLEGHENY
POLLACK, MD, HOWARD M	PHILADELPHIA
POLLACK, MD, IAN F	ALLEGHENY
POLLACK, MD, MATTHEW S	NORTHAMPTON
POLLAK, BRIAN M	STUDENT
POLLER, MD, WILLIAM R	ALLEGHENY
POLLICE, MD, PHILIP G	ALLEGHENY
POLLINO, MD, VINCENT	LACKAWANNA
POLLOCK, MD, ARTHUR E	BLAIR
POLLOCK, MD, BURTON H	ALLEGHENY
POLLOCK, MD, DENZEL W	MONTGOMERY
POLLOCK, DO, JAMES D	ERIE
POLLOCK, MD, JEFFREY L	PHILADELPHIA
POLLOCK, MD, MICHAEL S	INDIANA
POLSKY, MD, HARRY S	MONTGOMERY
POLSKY, STEWART M	STUDENT
POLSTER, MD, SCOTT D	MONTOUR
POMERANCE, MD, JAY F	PHILADELPHIA
POMERANTZ, DO, JEFFREY D	MERCER
POMERANTZ, MD, JOEL D	PHILADELPHIA
POMERANTZ, MD, MARC B	ALLEGHENY
POMERANTZ, MD, PHILIP A	BERKS
POMEROY, MD, JAMES M	DELAWARE
POMMERSHEIM, MD, WILLIAM J	LAWRENCE
POMPONIO, MD, JOSEPH G	NORTHAMPTON
PONCZ, MD, MORTIMER	PHILADELPHIA
POND, MD, HAROLD S	MONROE
PONTIUS, MD, JOHN G	LANCASTER
PONTZ, MD, JACK B	LANCASTER
PONTZER, MD, HERBERT	ELK/CAMERON
PONTZER, MD, PETER F	BLAIR
PONTZER, MD, RAYMOND E	ALLEGHENY
POOL, MD, CHAMPE C	DAUPHIN
POOLE, MD, ROBERT	CHESTER
POORE, MD, GEORGE C	POTTER
POORMAN, MD, S STURGIS	MONTGOMERY
POPAT, MD, ANJANA V	DAUPHIN
POPAT, MD, RAJNIKANT N	FAYETTE
POPE, MD, JOHN A	ALLEGHENY
POPE, DO, RONALD L	PHILADELPHIA
POPEY, MD, TRACY L C	ALLEGHENY
POPHAL, MD, MAHLON J	LYCOMING
POPICK, DO, ALAN J	WAYNE/PIKE
POPKAVE, MD, ARTHUR H	NORTHAMPTON
POPKO, BRIAN M	STUDENT
POPKY, MD, GEORGE L	PHILADELPHIA
POPOLOW, MD, MICHAEL L	MONTGOMERY
POPORAD, MD, GEORGE A	PHILADELPHIA
POPOVICH, MD, JOHN E	ALLEGHENY
POPPER, MD, DAVID A	BUCKS
PORCELAN, MD, JANE B	DELAWARE
PORITSKY, MD, SUSAN	PHILADELPHIA
PORKOLAB, MD, FREDERICK L	ALLEGHENY
PORRECA, MD, GEORGE A	PHILADELPHIA
PORT, MD, J TEIG	LACKAWANNA
PORT, MD, JOSHUA	BLAIR
PORTER, MD, ALBERT R	DAUPHIN
PORTER, MD, EDGAR L	CHESTER
PORTER, MD, ELIZABETH S	ALLEGHENY
PORTER, MD, I STANLEY	LANCASTER
PORTER, MD, MARY M	PHILADELPHIA
PORTER, MD, STEPHEN C	PHILADELPHIA
PORTER JR, MD, WILLIAM F	LANCASTER
PORTMAN, MD, MARY A	ALLEGHENY
PORTNER, MD, JAY H	PHILADELPHIA
PORTNER, MD, JEFF H	MONTGOMERY
PORTNOY, MD, LARRY NEAL	PHILADELPHIA
PORTNOY, MD, SCOTT L	ALLEGHENY
PORTZ, MD, MATTHEW C	ALLEGHENY
POSATKO, MD, BARBARA A	MONTGOMERY
POSNER, MD, JILL C	PHILADELPHIA
POSNER, DO, MICHAEL H	ADAMS
POSSANZA, MD, CARL J	LACKAWANNA
POST, MD, JAMES R	MONTGOMERY
POST, MD, JARVIS H	CAMBRIA
POST, MD, ROBERT M	LEHIGH
POSTICK, MD, KAREN R	PHILADELPHIA
POTASH, MD, GEORGE C	LEBANON
POTE JR, MD, HARRY H	CAMBRIA
POTERA, MD, LEO P	LUZERNE
POTH, ROBERT A	STUDENT
POTKONSKI, MD, LEOPOLD A	BERKS
POTNIS, MD, ASHA V	ALLEGHENY
POTOCHNY, MD, JOHN D	PHILADELPHIA
POTOK, DO, PAUL S	DAUPHIN
POTORSKI, MD, ROBERT D J	LUZERNE
POTSIC, MD, WILLIAM P	PHILADELPHIA
POTTASH, MD, RUBEN R	PHILADELPHIA
POTTER, MD, DONALD M	LEBANON
POTTER, MD, JEFFREY N	DAUPHIN
POTTER, MD, ROBERT H	ALLEGHENY
POTTER JR, MD, HOWARD P	CHESTER
POTTER JR, MD, ROBERT H	ALLEGHENY
POTTIPATI, MD, SUMANA R	ALLEGHENY
POTTS, MD, ASA W	CHESTER
POULIS, MD, DEMETRI T	LYCOMING
POULLIOTT JR, MD, JEROME W	LYCOMING
POUTOUS, MD, GEORGE W	ALLEGHENY
POWE, MD, LARRY K	DELAWARE
POWELL, MD, ALVIN P	BUCKS
POWELL, MD, JAMES R	FAYETTE
POWELL JR, MD, OSCAR M	ALLEGHENY
POWELL JR, DO, THOMAS F	PHILADELPHIA
POWER, MD, JOHN A	ALLEGHENY
POWERS, MD, BRIAN A	MONROE
POWERS, MD, DANAE M	CENTRE
POWERS, MD, DONALD V	DELAWARE
POWERS, MD, JOSEPH K	PHILADELPHIA
POWERS, MD, STEPHEN K	DAUPHIN
POWERS, MD, VICTOR J	LEHIGH
POWERS JR, MD, FRANCIS M	LYCOMING
POZNER, SAMANTHA B	STUDENT
PRABHU, MD, ANIL	ALLEGHENY
PRABHU, MD, NALINA	ALLEGHENY
PRADHAN, MD, ANIL G	MCKEAN
PRAGER, MD, DAVID	LEHIGH
PRAGER, MD, SIMEON	ALLEGHENY
PRAKASH, MD, MURTHAPPA N	LUZERNE
PRANCKUN, MD, PETER J	LANCASTER
PRANCKUN, MD, PETER P	LANCASTER
PRASAD, MD, AJIT K	CHESTER
PRASAD, MD, MAHADEVAPPA M	BUTLER
PRASAD, MD, MAHALINGIAH	ALLEGHENY
PRASAD, MD, SHISHIR C	LUZERNE
PRATER, MD, JOHN M	LUZERNE
PRATT, MD, DAVID S	DAUPHIN
PRATT, MD, LORETTA A	DELAWARE
PRAWDZIK, MD, LEOCADIA T	LUZERNE
PREATE, MD, DONALD L	LACKAWANNA
PRECIADO, MD, ALFONSO	ALLEGHENY
PREGLER, DO, FRANK C	ERIE
PREHATNY, MD, JOHN R	PHILADELPHIA
PREISS, MD, JENNIFER E	ALLEGHENY
PRELI, MD, OLINDO J	LACKAWANNA
PREMAZA-MUELLER, DO, ALICE R	PHILADELPHIA
PRENDERGAST, MD, MAURICE D	BEAVER
PRENDERGAST, MD, MICHAEL J	YORK
PRESS, MD, ALLAN J	ALLEGHENY
PRESSEL, MD, MICHAEL D	DELAWARE
PRESSMAN, MD, DEBORAH M	PHILADELPHIA
PRESSMAN, MD, EDMUND N	CHESTER
PRESSMAN, MD, ROBERT S	PHILADELPHIA
PRESTEL JR, MD, THOMAS F	DELAWARE
PRESTIFILIPPO, MD, ORAZIO	NORTHAMPTON
PRETTER, MD, PAUL D	ALLEGHENY
PRETTER, MD, PHILIP C	ALLEGHENY
PREUCEL, MD, ROBERT W	PHILADELPHIA
PREVOST, MD, JOHN V	TIOGA
PRIANO, STEVEN V	STUDENT
PRIBITKIN, MD, EDMUND	PHILADELPHIA
PRICE, MD, ALBERT C	LANCASTER
PRICE, MD, ALFRED R	ALLEGHENY
PRICE, MD, FREDRIC V	ALLEGHENY
PRICE, MD, RAPHAEL I	PHILADELPHIA
PRICE, MD, RICHARD E	CAMBRIA
PRICE, MD, RICHARD T	BUCKS
PRICE, MD, TAMARA L W	ALLEGHENY
PRICE, MD, TODD A	BLAIR
PRICE JR, MD, HENRY L	PHILADELPHIA
PRICE JR, MD, JOSEPH J	DELAWARE
PRICE JR, MD, STUART E	ALLEGHENY
PRIDE, MD, HOWARD B	MONTOUR
PRIEM, MD, ROBERT W	CHESTER
PRIMAK, MD, DMITRY	PHILADELPHIA
PRIMIANO, MD, GEORGE A	MONROE
PRIN, MD, WILLIAM A	ADAMS
PRINCE, MD, BEVERLY C	BRADFORD
PRINCE, MD, LESTER O	ALLEGHENY
PRINCE, MD, RICHARD B	BUCKS
PRINCIPATO, DO, ROBERT E	YORK
PRINGLE, MD, JACQUELINE M	ALLEGHENY
PRINGLE, MD, ROBERT W	ALLEGHENY
PRIOLO, MD, DENNIS L	LACKAWANNA
PRIOR, DO, JOHN E	LACKAWANNA
PRIOR, MD, PATRICIA A	DELAWARE
PRIORE, MD, ROBERT M	ALLEGHENY
PRIPSTEIN, MD, STEPHEN	MONTGOMERY
PRITT, MD, PAULINE	MONTGOMERY
PROBST, MD, SUSAN J	BERKS
PROCACCI, MD, PASQUALE M	PHILADELPHIA
PROCOPIO, MD, FRANK	DAUPHIN
PROCTOR, MD, JULIAN W	ALLEGHENY

PROCTOR, MD, MARGARET S PHILADELPHIA
PROCTOR, MD, MICHAEL S WAYNE/PIKE
PROKHOV, MD, VASSIL K ALLEGHENY
PROMISH, MD, DAVID S PHILADELPHIA
PROMISLOFF, DO, ROBERT A PHILADELPHIA
PROMUBOL, MD, YUWAREE WESTMORELAND
PRONCHIK, MD, DAVID J PHILADELPHIA
PROOTHI, MD, SUBHASH C LEHIGH
PROPST, MD, HARRY D WAYNE/PIKE
PROPST-PROCTOR, MD, SANDRA L WAYNE/PIKE
PROSPERI, MD, ALDO J WESTMORELAND
PROSTKO, MD, E RICHARD ALLEGHENY
PROTOMASTRO, PAUL D STUDENT
PROUDFIT, MD, J PAUL WASHINGTON
PROVAN, MD, CHARLES A ALLEGHENY
PROVAN, DO, NANCY M MONTGOMERY
PROVANCE, DO, WILLIAM J WESTMORELAND
PROVENCIO, MD, FLORENCIO LEBANON
PROWELL, MD, JOSEPH W LANCASTER
PROY, MD, BERNARD C ERIE
PRUCHNIC, MD, WILLIAM F CAMBRIA
PRUDENCIO, MD, MARIA E LEBANON
PRUDENCIO JR, MD, JOSE N DAUPHIN
PRUITT, MD, JOHN D MONTGOMERY
PRUSAKOWSKI, DO, JOSEPH M CLARION
PRYBLICK, DO, GARY M LEHIGH
PRYBLICK, DO, JUDITH R LEHIGH
PRYBYS, DO, KATHERINE M ALLEGHENY
PRYLINSKI, MD, GREGORY V ERIE
PRYLINSKI, DO, JEFFORY J ERIE
PRYOR JR, MD, CHARLES A BUCKS
PU, MD, GLEN A W FRANKLIN
PUCEVICH, MD, MARIA V ALLEGHENY
PUDLES, DO, DAVID M PHILADELPHIA
PUESAN, MD, REYNALDO WARREN
PUFFENBERGER, MD, MARK W LUZERNE
PUGH, MD, JAMES E PHILADELPHIA
PUGH, MD, REGINALD P ALLEGHENY
PUGLIESE, MD, AUGUST A ARMSTRONG
PUGLIESE, MD, JOSEPH F LUZERNE
PUGLIESE, MD, PATRICK D NORTHMBRLAND
PUGLISI, MD, ANTHONY S PHILADELPHIA
PUGLISI, MD, VINCENT PHILADELPHIA
PUJARA, MD, DEVI M SCHUYLKILL
PULITO, MD, JOHN M CRAWFORD
PULLEKINCS, MD, JOSEPH W ALLEGHENY
PULLEN, DO, CARL R PHILADELPHIA
PULLEN, MD, HARVEY T MONROE
PULLMAN-MOOAR, MD, SALLY W MONTGOMERY
PUMA, MD, SAMUEL J LUZERNE
PUNDIAK, MD, TERRY J NORTHAMPTON
PUNUKOLLU, MD, C RAO WESTMORELAND
PUPI, MD, PAUL A BEAVER
PUPPALA, SHAYM STUDENT
PURCELL, MD, ROBERT E ERIE
PURCELL, DO, STEPHEN M LEHIGH
PURCELL, SUSAN M STUDENT
PURCELL JR, MD, ROBERT E LYCOMING
PURDY, MD, RICHARD T LANCASTER
PURKAYASTHA, MD, ARINDAM SUSQUEHANNA
PURNELL, MD, JOHN S CENTRE
PURNER JR, DO, WILLIAM M DELAWARE
PURPURA, MD, THOMAS R ALLEGHENY
PURSELL, MD, ROBERT N NORTHAMPTON
PUSATERI JR, MD, JOSEPH P ALLEGHENY
PUSCHAK, MD, RUSSELL B LEHIGH
PUSHKAREWICZ, MD, MICHAEL J CHESTER
PUTNAM, MD, MARK A BERKS
PUTNAM III, MD, SAMUEL G MONTGOMERY
PUTPRUSH, MD, JOSEPH R LUZERNE
PYATT JR, MD, ROBERT S FRANKLIN
PYFER, MARK F STUDENT
PYLES, MD, MARK C COLUMBIA
PYTKO, MD, VALENTINE F MONTOUR

Q

QAYYUM, MD, IMRAN PHILADELPHIA
QUAGLIO, MD, NANNETTE D MERCER
QUALEY, MD, DEBORAH A MONTGOMERY
QUALLS, MD, DONALD M PHILADELPHIA
QUATTRONE, MD, CHARLES G ALLEGHENY
QUEEN, MD, GEORGE N ADAMS
QUERCI, DO, JOHN C LUZERNE
QUERIMIT, MD, JORGE A LYCOMING
QUEVEDO, MD, JONATHAN P LEHIGH
QUICKEL, MD, KENNETH E DAUPHIN
QUIGLEY, MD, MATTHEW R ALLEGHENY
QUILL, MD, JOSEPH R MONTGOMERY
QUILO, MD, LINO S NORTHAMPTON
QUINEY JR, MD, JAMES J NORTHAMPTON
QUINN, MD, DIANNE M BUCKS
QUINN, MD, GRAHAM E PHILADELPHIA
QUINN, MD, JOHN R CAMBRIA
QUINN, DO, PHILIP L MIFFLIN/JUNIATA
QUINN JR, MD, NORMAN J MONTGOMERY
QUINT, MD, ANDREW R MONTGOMERY
QUINT, MD, DONALD H ALLEGHENY
QUINTANA, MD, BENJAMIN J DAUPHIN
QUINTERO, MD, MIGUEL J ALLEGHENY
QUIRANTES, MD, MIRTA BERKS
QUIRING, MD, MARK E BERKS
QUIRK, MD, BRIAN C DAUPHIN
QURESHI, DO, AMIL M MIFFLIN/JUNIATA

R

RAAB, MD, DAVID B LANCASTER
RAAB, MD, MICHAEL F NORTHAMPTON
RABER, MD, IRVING M PHILADELPHIA
RABIN, MD, HAROLD S DAUPHIN
RABIN, MD, SIDNEY C CHESTER
RABINOVICI, MD, REUVEN PHILADELPHIA
RABINOWITZ, MD, HOWARD K PHILADELPHIA
RABINOWITZ, DO, JOSHUA A DELAWARE
RABKIN, MD, MICHAEL S ALLEGHENY
RABSON, MD, JOSEPH A MONTGOMERY
RABSON, MD, MOSES PHILADELPHIA
RACCIATO, MD, PETER J MONROE
RACE, MD, DAVID F ERIE
RACETTE, MD, C DYEANNE LANCASTER
RACH, MD, JOEL F WASHINGTON
RACHO, MD, GEORGE J LUZERNE
RACKISH, MD, MARK A LYCOMING
RACKOW, MD, LAWRENCE L PHILADELPHIA
RAD, BABAK N STUDENT
RADBILL, MD, SIDNEY G PHILADELPHIA
RADECKI, MD, PAULA J PHILADELPHIA
RADFAR, MD, FEREYDOON D ALLEGHENY
RADFAR, MD, NEZAM ALLEGHENY
RADFAR, MD, ROUHANGIZ H ALLEGHENY
RADFAR, MD, SORAYA Z ALLEGHENY
RADICE, MD, EUGENE D COLUMBIA
RADIS, MD, MALKA B CLEARFIELD
RADLER, MD, JOHN K BEAVER
RADON, PAULA A STUDENT
RADOSH, LEE J STUDENT
RADSMA, MD, DOUWE L ADAMS
RAEZER, MD, DAVID M DELAWARE
RAFALKO, MD, DAVID M BEAVER
RAFEI, KEYVAN STUDENT
RAFELSON, MD, STEPHEN A BUCKS
RAFF, MD, H BARRY DELAWARE
RAFF, MD, THOMAS C LANCASTER
RAFFENSPERGER, MD, BRUCE W PHILADELPHIA
RAFFERTY, MAUREEN STUDENT
RAFFERTY, DO, MICHAEL F PHILADELPHIA
RAGONESI, MD, SUSAN B PHILADELPHIA
RAGOOR, MD, BALAKRISHNA R WESTMORELAND
RAGOOWANSI, MD, ASHVIN T ALLEGHENY
RAGOOWANSI, MD, TULSIDAS N BEAVER
RAHAM, MD, DAVID C DAUPHIN
RAHAUSER, MD, DAVID M FRANKLIN
RAHIM, MD, ENAYET CAMBRIA
RAHMAN, MD, RUKHSANA K ADAMS
RAHMAN, MD, SAEED U ALLEGHENY
RAHMANIAN, MD, NADER BERKS
RAHNER, MD, RICHARD A ERIE
RAICH, MD, WILLIAM A LANCASTER
RAIFORD, MD, JOHN W BUCKS
RAIMONDO, MD, MASSIMO DELAWARE
RAINES, MD, HERBERT S PHILADELPHIA
RAINES, MD, JONATHAN M PHILADELPHIA
RAINEY, MD, CYNTHIA L CAMBRIA
RAINEY, MD, EDWARD C BLAIR
RAINEY, DO, MICHAEL J LACKAWANNA
RAISCH, MD, FREDERICK J MERCER
RAIZMAN, MD, RICHARD E ALLEGHENY
RAJ, MD, STEPHEN S ERIE
RAJASEKHARA, PADMA STUDENT
RAJASENAN, KIRAN K STUDENT
RAJASENAN, MD, VASUDEVAN BEAVER
RAJJOUB, MD, RODWAN K LYCOMING
RAJTER, JEAN-JACQUES STUDENT
RAJU, MD, PADMA I BLAIR
RAJU, MD, RUDRARAJU P BLAIR
RAKINIC, MD, JAN PHILADELPHIA
RAKLEWICZ, MD, MICHAEL C LUZERNE
RALPH, MD, NATHAN PHILADELPHIA
RALSTON, MD, EDGAR L PHILADELPHIA
RAM, MD, NAND PHILADELPHIA
RAM, MD, SANT ERIE
RAMACHANDRAN, MD, MOORIATH LAWRENCE
RAMACIOTTI, MD, CLAUDIO PHILADELPHIA
RAMAGE, MD, ANN L YORK
RAMAKRISHNAN, MD, THEKKEMADOM P NORTHAMPTON
RAMAN, MD, JAYALAXMI PHILADELPHIA
RAMANATHAN, MD, DEBORAH BUCKS
RAMBACH, MD, LEONARD LANCASTER
RAMDIAL, MD, HORACE L PHILADELPHIA
RAMESH, MD, MAKUM L ALLEGHENY
RAMIK, MD, OTTO E ALLEGHENY
RAMINANI, MD, LOKADRI N MONTGOMERY
RAMIREZ, MD, CONSTANCIO FRANKLIN
RAMIREZ, MD, REBECCA O ALLEGHENY
RAMIREZ, MD, RENATO P CRAWFORD
RAMIREZ-AMAYA, MD, RENE NORTHAMPTON
RAMOS, MD, CLARITA P WESTMORELAND
RAMOS-CARO, MD, JOSE L LEHIGH
RAMS, MD, JAMES J ALLEGHENY
RAMSEY II, MD, WILLIAM H MONTGOMERY
RAMSEY JR, MD, HARRY E BERKS
RAMUNDO, MD, GIOVANNI B DAUPHIN
RANCIER, MD, LEE F LACKAWANNA
RANCK, MD, SIDNEY G BRADFORD
RAND, MD, ELIZABETH B PHILADELPHIA
RANDALL, MD, J PERLINGIERO MONTGOMERY
RANDALL, MD, JOHN L PHILADELPHIA
RANDALL, MD, PETER PHILADELPHIA
RANDALL, MD, RODNEY R ALLEGHENY
RANDALL IV, MD, ALEXANDER MONTGOMERY
RANGANATH, MD, GUBBI N SCHUYLKILL
RANIERI, DO, JOSEPH N PHILADELPHIA
RANIERI, MD, TITO A PHILADELPHIA
RANISH, MD, DEBORAH A ERIE
RANKIN, MD, JAMES S ALLEGHENY
RANKIN, MD, KEVIN P BUTLER
RANKIN, MD, LARRY S CUMBERLAND
RANKIN, MD, ROBERT C ALLEGHENY
RANNELS, MD, HERMAN W LYCOMING
RANUCCI-WEISS, MD, DENISE A PHILADELPHIA
RAO, MD, B VENKAT ALLEGHENY
RAO, MD, BRINDA E CHESTER
RAO, MD, KASUGANTI V ALLEGHENY
RAO, MD, LEELA K ALLEGHENY
RAO, MD, MADHAVA S LACKAWANNA
RAO, MD, NALINI ALLEGHENY
RAO, MD, RAMDEV K ALLEGHENY
RAO, MD, SUNDER R ALLEGHENY
RAO, MD, USHA G YORK
RAO, MD, VIJAY M PHILADELPHIA
RAO, MD, YASHODA D SCHUYLKILL
RAPHAEL, MD, PAUL S LEHIGH
RAPHAEL, MD, STEPHEN A MONTGOMERY
RAPHAELY, MD, RUSSELL C PHILADELPHIA
RAPPAPORT, MD, ELIZABETH B MONTGOMERY
RAPPAPORT, MD, LEWIS B ALLEGHENY
RAPPAPORT, MD, MELVIN M LEHIGH
RASCHID, MD, SOHAEL M FRANKLIN
RASCOE JR, MD, ROBERT R PHILADELPHIA
RASEFSKE, JASON P STUDENT
RASHID, MD, ABDUL SCHUYLKILL
RASHID, MD, MOHAMMAD PHILADELPHIA
RASHID, MD, SAMUEL F LEBANON
RASHKIS, MD, HAROLD A PHILADELPHIA
RASLEAR-HENDRICKSON, MD, MARIA A DELAWARE
RASO, MD, DOMINIC J NORTHAMPTON
RATH, KRISTINA M STUDENT
RATHORE, MD, DALEEP K ALLEGHENY
RATINI, DO, ANGELO J BUCKS
RATKE, MD, HENRY V LYCOMING
RATNER, MD, ERIC R PHILADELPHIA
RATNER, MD, LARRY M BUCKS
RATNER, MD, RICHARD R DELAWARE
RATSCHAN, MD, WALTER J ALLEGHENY
RAU, MD, RAMNATH S MERCER
RAU, MD, RAYMOND L ALLEGHENY
RAUB, MD, JAMES A ALLEGHENY
RAUB, MD, JEFFREY D VENANGO
RAUBENSTINE, MD, DEBORAH A CUMBERLAND
RAUCH, MD, DOUGLAS MERCER
RAVANDOOST, MD, PARVANEH PHILADELPHIA
RAVANO, MD, JOSE F ALLEGHENY
RAVEL, MD, ROBERT L MONTGOMERY
RAVELLA, MD, SARATH B LACKAWANNA
RAVES, MD, JOHN J ALLEGHENY
RAVETZ, PAMELA C STUDENT
RAVETZ, DO, ROBERT S PHILADELPHIA
RAVINDRAN, MD, SRINIVASAN ALLEGHENY
RAVIOLA, MD, CAROL ANN PHILADELPHIA
RAVITZ, MD, GERALD A SCHUYLKILL
RAWA, RANDY S STUDENT
RAWNSLEY, MD, HERBERT H WASHINGTON
RAWSON, MD, HELEN H MONTGOMERY
RAY, ANDREA O STUDENT
RAY, MD, ANNMARIE BEAVER
RAY, MD, JOHN H ALLEGHENY
RAY, MD, RICHARD L ALLEGHENY
RAY, MD, TARUN K PHILADELPHIA
RAYBECK-DE VLIEGER, KELLI J STUDENT
RAYMOND, MD, JOSEPH W CAMBRIA
RAYMOND JR, MD, FRED D MONTGOMERY
RAYMUNDO, MD, ROSALINDA R LAWRENCE
RAYMUNDO III, MD, RICARDO B LAWRENCE
RAYNAK, MD, FRANK R MERCER
RAYNES, MD, STANTON M BUCKS
RAZA, MD, HASHIM ALLEGHENY
RAZDAN, MD, BHARTI PHILADELPHIA
RAZURI, MD, RAFAEL G NORTHAMPTON
RAZZINO, MD, RICHARD A DAUPHIN
READ, MD, FRANK PHILADELPHIA
READ, MD, JANE C BEAVER
REAGAN, MD, MARIE A ALLEGHENY
REAL, MD, MARK B CHESTER
REAMS, MD, CARL L MONTOUR
REAMS, DO, JEAN M MIFFLIN/JUNIATA
REARDON JR, MD, PAUL L WASHINGTON
REAVES, DO, LORI A LUZERNE
REBELLO, MD, SUNIL D BLAIR
RECALDE, MD, CARLOS M MIFFLIN/JUNIATA
RECH, MD, FRANK M DELAWARE
RECIO, MD, ROLANDO G ALLEGHENY
RECKER, MD, SCOTT F BLAIR
RECTOR, MD, ROBERT D FRANKLIN
RED, MD, DONALD E DELAWARE
REDA, MD, FRANK A ALLEGHENY
REDAN, MD, JAY A WYOMING
REDCAY, DO, JULIA E MONTOUR
REDDING, MD, WILLIS A BRADFORD
REDDY, MD, GAYATRI P PHILADELPHIA
REDDY, MD, JAIVEER T CLARION
REDDY, MD, PATRICIA A DAUPHIN
REDDY, MD, PUSHPAMALA P ARMSTRONG
REDDY, MD, RAGOOR K ALLEGHENY
REDDY, MD, RAJIDI M LYCOMING
REDDY, MD, RAVICHANDRA PHILADELPHIA
REDDY, MD, VIJAYANTI K LEHIGH
REDKA, MD, JAMES W LYCOMING
REDMOND III, MD, JOHN MONTGOMERY
REDOVAN, MD, EDWARD G LAWRENCE
REED, MD, CLIFFORD A BERKS
REED, MD, CRYSTAL D PHILADELPHIA
REED, MD, DARRELL K ALLEGHENY
REED, MD, DAVID M ALLEGHENY
REED, MD, JANIS E ALLEGHENY
REED, MD, KRISTYN M PHILADELPHIA
REED, MD, LOLA S CHESTER
REED, MD, MARK S BERKS
REED, MD, MICHAEL F CLEARFIELD
REED, SCOTT F STUDENT
REEDMAN, MD, GAIL A BUCKS
REEDY, MD, BRIAN K PHILADELPHIA
REEDY, MD, GARY L LACKAWANNA
REEGER, MD, WENDY L ALLEGHENY
REEL, MD, CHARLES M WESTMORELAND
REES, MD, CHRISTOPHER J PHILADELPHIA
REES, MD, DAVID B BERKS
REESE, CARL T STUDENT
REESE, MD, FRED W COLUMBIA
REESE, MD, RICHARD W LANCASTER
REESE JR, MD, EVAN C NORTHAMPTON
REEVE, AMANDA D STUDENT
REFFINO PEREYRA, MD, MARIA R PHILADELPHIA
REFOWICH, MD, RICHARD S NORTHAMPTON
REGALADO, MD, REGULUS D UNION
REGAN, MD, JAMES R NORTHAMPTON
REGAN, MD, MARK C LANCASTER
REGANIS, MD, JOHN C NORTHAMPTON
REGEC, MD, STEPHEN P ELK/CAMERON
REGINELLA, MD, RUTHANE F ALLEGHENY
REGOSO, MD, DAN C ALLEGHENY
REHDER, MD, JOHN G ALLEGHENY
REHDER, MD, KAREN E ALLEGHENY
REHR, MD, ROGER B BERKS
REICH, MD, SYLVIA R LUZERNE
REICH, MD, WILLIAM P TIOGA
REICHARD, MD, JAMES L CENTRE
REICHARD, MD, PETER S PHILADELPHIA
REICHWEIN, MD, RAYMOND K DAUPHIN
REID, MD, DANIEL W DELAWARE
REID, MD, JAMES H NORTHAMPTON
REID, MD, LISA R DAUPHIN
REID-ARTIST, MD, JACINTH M PHILADELPHIA
REIDELL, MD, JOHN S CENTRE
REIDY, MD, MARGARET E ALLEGHENY
REIFSNYDER, MD, WILLIAM H BERKS
REIGART, MD, PAUL M YORK
REIGEL, MD, DONALD H ALLEGHENY
REIGH, MD, ERNEST E BERKS
REILEY, DO, MARGARET A BERKS
REILLY, MD, ANN E CHESTER
REILLY, MD, CHARLES M YORK
REILLY, MD, DESMOND J DAUPHIN
REILLY, MD, JAMES J ALLEGHENY
REILLY, MD, JOHN C ERIE
REILLY, JOHN P STUDENT
REILLY, MD, MICHAEL J FAYETTE
REILLY, MD, PAUL A ALLEGHENY
REILLY, MD, PHILLIP E FAYETTE
REILLY, DO, ROBERT E BUCKS
REILLY JR, MD, JAMES J ALLEGHENY
REILLY JR, MD, PHILIP J WESTMORELAND
REIMER, MD, CRAIG L SCHUYLKILL
REINA, MD, CHARLES R NORTHAMPTON
REINACH, MD, ALAN J PHILADELPHIA
REINBOLD, MD, PAUL M LEHIGH
REINECKE, MD, ROBERT D PHILADELPHIA
REINER, MD, REBECCA L BERKS
REINHARD, MD, DAVID L PHILADELPHIA
REINHARD, MD, HAROLD J WARREN
REINHARD, MD, RONALD J YORK
REINHARDT, MD, PAULINE K LEHIGH
REINHART, MD, JOHN W LEHIGH
REINHART JR, MD, RAYMOND B BUCKS
REINPRECHT, MD, JAMES T PHILADELPHIA
REIS, MD, CLAUDE J ALLEGHENY
REIS, MD, GREGG J PHILADELPHIA
REIS, MD, PAUL B LYCOMING
REIS, MD, WALTER J ALLEGHENY
REISCHEL, MD, ULRICH A PHILADELPHIA
REISER, MD, HARVEY J LUZERNE
REISH, TIMOTHY G STUDENT
REISH, MD, WILLIAM G UNION
REISINGER, MD, SUSAN A PHILADELPHIA
REISINGER JR, MD, WILLIAM E SOMERSET
REISS III, MD, G RUSSELL PHILADELPHIA
REISS JR, MD, G RUSSELL MONTGOMERY
REITANO, MD, JOHN PHILADELPHIA
REITER, MD, DAVID PHILADELPHIA
REITER, GEORGE T STUDENT
REITER, MD, SEAN B PHILADELPHIA
REITSMA, MD, DOUGLAS B DELAWARE
REITZ, MD, MARYELLEN ERIE
REITZ, MD, MELVIN L SCHUYLKILL
RELIGIOSO, MD, ELOISA P WESTMORELAND
RELOVA, DO, RODERICK M BUCKS
RELTON, MD, SUDHAKAR C ALLEGHENY
RELUZ, MD, JAVIER S MONTGOMERY
REMALY, MD, DONALD A COLUMBIA
REMICK, DO, PAUL F LACKAWANNA
RENDIN, MD, LARRY J DELAWARE
RENINGER, MD, CHARLES W LEHIGH
RENKERT, MD, ELIZABETH E BERKS
RENNINGER, EXEC SEC, RHONDA S YORK
RENO, MD, JOSEPH D DELAWARE
RENTON, MD, ALAN C ALLEGHENY
RENZ, MD, ROBERT T ERIE
REPLOGLE, CORINNE R STUDENT
REPPERT, MD, WILLIAM D NORTHAMPTON
RESCINITI, MD, MARK A ADAMS
RESHMI, MD, CHANDRAPPA S ALLEGHENY
RESNICK, MD, ALBERT B PHILADELPHIA
RESNICK, MD, EDWARD J PHILADELPHIA
RESNICK, MD, GEORGE J PHILADELPHIA

RESNICK, MD, MYRON E DELAWARE
RESNICK, MD, PAUL H ALLEGHENY
RESNICK, PETER F STUDENT
RESPET, MD, PATRICK B LEHIGH
RESTREPO, MD, JAMES P BERKS
RESURRECCION, MD, ROSARIO PHILADELPHIA
RETTIG, MD, STEPHEN J FRANKLIN
REUBEN, MD, MARK S BERKS
REUSCHE III, DO, FRANK L ERIE
REVAK, MD, BLAIRANNE H COLUMBIA
REVAK, DO, DAVID J COLUMBIA
REX, MD, JAMES C LEHIGH
REYES, MD, SATURNINO M BEAVER
REYES, MD, VICENTE E ALLEGHENY
REYNA, MD, OSCAR D WESTMORELAND
REYNER, MD, PETER C BERKS
REYNOLDS, MD, HERBERT Y DAUPHIN
REYNOSO, MD, ZORAIDA L PHILADELPHIA
REZAIAN, MD, MICHAEL M BUTLER
REZEK, MD, DONALD L ALLEGHENY
REZNAK, MD, STEPHEN E PHILADELPHIA
REZNICK, MD, BARRY R BEAVER
RHAUDA, PATRICIA P STUDENT
RHEE, MD, YONG H LUZERNE
RHEINBOLT, MD, RICHARD M PHILADELPHIA
RHIEW, MD, FRANCIS C LACKAWANNA
RHOA, MD, MATTHEW F PHILADELPHIA
RHOADES, DO, DENNIS W JEFFERSON
RHOADS, MD, HARRY M CAMBRIA
RHOADS JR, MD, JONATHAN E YORK
RHOADS SR, MD, JONATHAN E PHILADELPHIA
RHODE, MD, MARVIN C MONTGOMERY
RHODES, MD, ANTHONY L LACKAWANNA
RHODES, MD, ARTHUR R ALLEGHENY
RHODES, DONALD R STUDENT
RHODES, MD, MICHAEL LEHIGH
RHODES, MD, ROBERT A DELAWARE
RHODES III, MD, LUTHER V LEHIGH
RHOOD, MD, SAMUEL G DELAWARE
RIAL, MD, WILLIAM Y DELAWARE
RIBAUDO, MD, JANICE WESTMORELAND
RIBEN, MICHAEL W STUDENT
RICCELLI, MD, ANTONIO M ALLEGHENY
RICCHETTI, MD, ROBERT J PHILADELPHIA
RICCHIUTI, MD, A GEORGE SCHUYLKILL
RICCHIUTI, MD, JOSEPH F SCHUYLKILL
RICCI, MD, ANTHONY N ALLEGHENY
RICCI, MD, JOSEPH A DAUPHIN
RICCO, MD, ERNEST J DELAWARE
RICE, MD, DONALD H BLAIR
RICE, MD, EILEEN M ALLEGHENY
RICE, MD, GEORGE E PHILADELPHIA
RICE, KEITH S STUDENT
RICE, MD, NATALIE M LEHIGH
RICE, MD, SAMUEL A LANCASTER
RICE, MD, SAMUEL M ALLEGHENY
RICH, MD, DEAN C MONTGOMERY
RICH, MD, J JEFFREY ALLEGHENY
RICH, MD, JAMES F DAUPHIN
RICHARDS, MD, ANDREW J DAUPHIN
RICHARDS, MD, CHARLES H ALLEGHENY
RICHARDS, MD, DAVID S WESTMORELAND
RICHARDS, MD, DAVID T LACKAWANNA
RICHARDS, MD, JOHN C BUCKS
RICHARDS, MD, ROBERT N FRANKLIN
RICHARDS, MD, STEPHANIE S ALLEGHENY
RICHARDS JR, MD, ROBERT N FRANKLIN
RICHARDSON, MD, DAVID W PHILADELPHIA
RICHARDSON, MD, GEORGE S ALLEGHENY
RICHARDSON, MD, HARRISON H BEAVER
RICHARDSON, MD, JAMES E WASHINGTON
RICHARDSON, MD, MONIQUE A ALLEGHENY
RICHARDSON, MD, PAUL A PHILADELPHIA
RICHERT, MD, CHARLES A ALLEGHENY
RICHERT, MD, SHAUNA M ALLEGHENY
RICHERTS, MD, JOSEPH L PHILADELPHIA
RICHEY, MD, JAMES E CAMBRIA
RICHIE, MD, A THOMAS BUCKS
RICHMAN, MD, CRAIG G ERIE
RICHMAN, MD, JORY D ALLEGHENY
RICHMAN, MD, KENNETH A PHILADELPHIA
RICHMAN, MD, MORTON W MONTGOMERY
RICHMAN, MD, TOBI B ERIE
RICHMOND, MD, ALLEN C PHILADELPHIA
RICHMOND, MD, SPENCER I MONTGOMERY
RICHTER, MD, DOUGLAS M MONTGOMERY
RICHTER, MD, HOWARD A DELAWARE
RICHTER, MD, MELVYN P MONTGOMERY
RICHTER, MD, PAUL L ALLEGHENY
RICHTERMAN, MD, RONALD L LUZERNE
RICKETTS, MD, MARY F ALLEGHENY
RICKLOFF, MD, RAYMOND J ERIE
RICKMAN, CHRISTOPHER E STUDENT
RICKS, MD, JOHN E CUMBERLAND
RICTOR, MD, KENNETH W FRANKLIN
RIDELLA, MD, PETER J CAMBRIA
RIDEN, MD, ALICE E LANCASTER
RIDGWAY, MD, WILLIAM G LANCASTER
RIDOUT III, MD, DANIEL L DELAWARE
RIED, MD, STEPHANIE R PHILADELPHIA
RIEDER, MD, MICHAEL J MONTGOMERY
RIEMER, MD, BARRY L ALLEGHENY
RIENZI, MD, JOSEPH P LACKAWANNA
RIENZO, MD, ROBERT J LEHIGH
RIETHER, MD, ROBERT D LEHIGH
RIFE, MD, CHARLES J DAUPHIN
RIFFERT, MD, PAUL M LANCASTER
RIGAL, MD, RENE R LYCOMING
RIGANO JR, MD, RUDOLPH F LANCASTER
RIGG, MD, L ISOBEL PHILADELPHIA
RIGGALL, MD, STEVEN O MERCER
RIGHTMYER, MD, JOHN N BERKS
RIGHTOR, MD, JOHN T VENANGO
RIGHTS, MD, THEODORE H BERKS
RIGNEY JR, MD, JAMES H BUCKS
RIGOTTI, DO, JOSEPH A MONTGOMERY
RIKE, MD, PAUL M ALLEGHENY
RILEY, MD, BERNARD J ALLEGHENY
RILEY, DO, JUDITH A PHILADELPHIA
RILEY, MD, VALERIE J MONTGOMERY
RILEY, MD, VERYL M WARREN
RILLING, MD, DAVID C BUCKS
RIM, MD, JEUNG K LEBANON
RIMPLE, MD, DAVID F LUZERNE
RINARD, MD, GRAFFIOUS L BEDFORD
RINCON-VERACOECHEA, MD, GUNTHER A PHILADELPHIA
RING, MD, ILONA R DELAWARE
RINGIEWICZ, MD, PAUL A DELAWARE
RINGLER JR, MD, HAROLD L CAMBRIA
RINGOLD, MD, MURRAY H BUCKS
RINKER, MD, R JAMES YORK
RINKOFF, MD, JEFFREY S ALLEGHENY
RIPEPI, MD, JENNIFER K ALLEGHENY
RIPEPI, MD, PHILIP P ALLEGHENY
RIPPERT, DO, JUDITH A MONTGOMERY
RIPPLE, MD, PAUL H LANCASTER
RISH, MD, BENITO B PHILADELPHIA
RISING, MD, DAVID C BUCKS
RISMILLER, MD, ROSS W SCHUYLKILL
RIST, MD, KEVIN E ALLEGHENY
RITCHIE, MD, CHARLES A DELAWARE
RITCHIE, MD, DAVID J PHILADELPHIA
RITCHIE, MD, LAURENCE T ALLEGHENY
RITCHIE, MD, MARIANNE T DELAWARE
RITCHIE III, MD, JOHN C PHILADELPHIA
RITSEMA, MD, RITA L DELAWARE
RITTENBERG, MD, MICHAEL H LUZERNE
RITTENHOUSE, MD, ERIC R YORK
RITTENHOUSE, MD, FRANK H ALLEGHENY
RITTENHOUSE, MD, JEFFREY B LANCASTER
RITTER, MD, CHARLES W PHILADELPHIA
RITTER, MD, DEBORAH E PHILADELPHIA
RITTER, MD, THOMAS J SCHUYLKILL
RITZ, MD, GEORGE LUZERNE
RIVAS, MD, DAVID A MONTGOMERY
RIVAS, MD, STEVEN PHILADELPHIA
RIVAS-FLORES JR, MD, AURELIANO MONTGOMERY
RIVERA, MD, EDWIN A YORK
RIVERA, MD, JOSE L NORTHAMPTON
RIVERA, MD, MARIA-JOSEFINA DELAWARE
RIVERA, MD, VICTOR C BUCKS
RIVERA-RODRIGUEZ, MD, GABRIEL JEFFERSON
RIVIELLO, MD, RALPH J STUDENT
RIXEY, MD, CHARLES O MONTOUR
RIZK, MD, HANI ALLEGHENY
RIZVI, MD, SYED ASIF R PHILADELPHIA
RIZZO, MD, JOHN S DELAWARE
RIZZO, MD, KAREN A LANCASTER
RIZZO, MARCO STUDENT
RO, MD, PAMELA S ALLEGHENY
ROACH, MD, ALICE J YORK
ROACHE, MD, MARTIN J CHESTER
ROBA, MD, LAURIE A ALLEGHENY
ROBB, MD, MARIE E NORTHAMPTON
ROBBINS, MD, ELIZABETH L PHILADELPHIA
ROBBINS, MD, HOWARD S LANCASTER
ROBBINS, MD, INGA H PHILADELPHIA
ROBBINS, KENT C STUDENT
ROBBINS, MD, MARK S PHILADELPHIA
ROBBINS, MD, ROBERT PHILADELPHIA
ROBBINS, DO, SUSAN E ERIE
ROBBINS, MD, WARREN J LANCASTER
ROBBINS, MD, WILLIAM S PHILADELPHIA
ROBERTI, MD, NICHOLAS E JEFFERSON
ROBERTO, MD, PAUL J PHILADELPHIA
ROBERTS, MD, ANDREW B PHILADELPHIA
ROBERTS, MD, BROOKE PHILADELPHIA
ROBERTS, MD, HASKELL E LANCASTER
ROBERTS, MD, JOAN M PHILADELPHIA
ROBERTS, MD, JOHN H CHESTER
ROBERTS, MD, JOHN M PHILADELPHIA
ROBERTS, MD, LENORE B MONTGOMERY
ROBERTS, DO, ROBERT L YORK
ROBERTS, MD, STEVEN A PHILADELPHIA
ROBERTS JR, MD, PHILIP G CENTRE
ROBERTSON, MD, JAMES F MONTGOMERY
ROBERTSON, MD, JOHN J BERKS
ROBERTSON, MD, JOHN L WARREN
ROBERTSON, MD, JOHN W PHILADELPHIA
ROBERTSON, DO, LISA E LUZERNE
ROBERTSON JR, MD, THOMAS L ALLEGHENY
ROBIN, DO, SARAH E BUCKS
ROBINSON, MD, CLAIRE E B PHILADELPHIA
ROBINSON, MD, FREDERICK A PHILADELPHIA
ROBINSON, MD, GARY BERKS
ROBINSON, MD, JAMES A YORK
ROBINSON, MD, JAY A BLAIR
ROBINSON, MD, JOHN N ALLEGHENY
ROBINSON, MD, JOSEPH LUZERNE
ROBINSON, MD, KEVIN G PHILADELPHIA
ROBINSON, MD, LESLIE E YORK
ROBINSON, MD, MICHAEL L BERKS
ROBINSON, MD, MICHAEL L BUCKS
ROBINSON, MD, MURRAY D PHILADELPHIA
ROBINSON, MD, NATHANIEL M PHILADELPHIA
ROBINSON II, MD, GEORGE R YORK
ROBINSON JR, MD, ELLIOTT S BRADFORD
ROBINSON JR, MD, WARREN L LYCOMING
ROBISON, DO, CAROL K CUMBERLAND
ROBISON, MD, ELIZABETH A CHESTER
ROBISON, MD, ROBERT N DAUPHIN
ROBISON, DO, TERRY A CUMBERLAND
ROBISON, MD, WALTER J ALLEGHENY
ROBSON, MD, PETER A NORTHAMPTON
ROBY, MD, DAVID S PHILADELPHIA
ROCCARIO, DO, DANTE S DELAWARE
ROCCO, MD, MARTIN J PHILADELPHIA
ROCCO, MD, NICHOLAS J PHILADELPHIA
ROCHE, MD, JAMES J LACKAWANNA
ROCHE, MD, KAREN R ALLEGHENY
ROCHMAN, MD, ALAN J DAUPHIN
ROCK, MD, IRA M ALLEGHENY
ROCK, MD, JAMES A CAMBRIA
ROCK, MD, LEONARD L SOMERSET
ROCKOFF, MD, STEVEN D LYCOMING
ROCKOWER, MD, ROGER A CENTRE
RODA, DO, DAVID M LANCASTER
RODA, MD, PAUL I LUZERNE
RODAS, DO, RAUL A DAUPHIN
RODENBERGER, MD, BRUCE M LEHIGH
RODGERS, MD, CHARLES J LYCOMING
RODGERS, MD, DAVID M PHILADELPHIA
RODGERS, MD, FLORENCE E PHILADELPHIA
RODGERS, MD, JOSEPH F PHILADELPHIA
RODGERS, MD, TIMOTHY J PHILADELPHIA
RODGERS III, MD, WILLIAM H MONTGOMERY
RODRIGO, MD, CONCEPCION V LUZERNE
RODRIGUES, MD, JAMES ALLEGHENY
RODRIGUEZ, MD, ALFONSO LUZERNE
RODRIGUEZ, MD, DAISY A PHILADELPHIA
RODRIGUEZ, MD, EDSEL A NORTHMBRLAND
RODRIGUEZ, MD, ERNESTO C BUCKS
RODRIGUEZ, MD, GEORGE L PHILADELPHIA
RODRIGUEZ, MD, HUGO F DELAWARE
RODRIGUEZ, MD, JULIO A BLAIR
RODRIGUEZ, MD, NORBERTO A ALLEGHENY
RODRIGUEZ, MD, RAYMOND PHILADELPHIA
RODRIGUEZ, MD, RODOLFO E DAUPHIN
RODRIGUEZ, MD, VICTOR R NORTHAMPTON
RODRIGUEZ-FEO, MD, RAUL CAMBRIA
ROE, MD, EUGENE J LACKAWANNA
ROE, MD, ROBERT E LUZERNE
ROEDDER, MD, SUSAN L PHILADELPHIA
ROEDER, MD, DONALD K CUMBERLAND
ROEDER, MD, KATHLEEN M BUCKS
ROEDIGER, MD, PAUL M MONTGOMERY
ROESER, MD, MINDI M PHILADELPHIA
ROESHOT, MD, DOUGLAS E CENTRE
ROFSKY, MD, HOWARD E CHESTER
ROGAL, MD, MICHAEL J ALLEGHENY
ROGALLA, MD, CHARLES S LACKAWANNA
ROGERS, MD, ALBERT K LANCASTER
ROGERS, MD, BRUCE W UNION
ROGERS, MD, GEORGE E CAMBRIA
ROGERS, MD, JAMES F PHILADELPHIA
ROGERS, DO, JEFFREY S LEHIGH
ROGERS, MD, JOHN F NORTHAMPTON
ROGERS, MD, KENNETH J CENTRE
ROGERS, MD, PAUL H CHESTER
ROGERS, MD, R CLAUDE PHILADELPHIA
ROGERS, MD, VINCENT P ERIE
ROGERS, MD, WILLIAM E LUZERNE
ROGERS JR, MD, ROBERT M BERKS
ROGERSON, MD, DAVID R CAMBRIA
ROGEVICH, DO, JOSEPH E LANCASTER
ROGINA, DO, LAWRENCE E FRANKLIN
ROGOVITZ, MD, DAVID M SCHUYLKILL
ROGOW, MD, EDWARD ALLEGHENY
ROGOWSKI, MD, RAYMOND A CHESTER
ROGUSKY, MD, EDWIN J CENTRE
ROHATGI, MD, ANITA NORTHAMPTON
ROHATGI, MD, CHAND NORTHAMPTON
ROHATGI, MD, RAJEEV NORTHAMPTON
ROHLAND, MD, DONALD V DAUPHIN
ROHNER JR, MD, THOMAS J DAUPHIN
ROHR, MD, ALBERT S MONTGOMERY
ROHRABAUGH JR, MD, CHARLES M DAUPHIN
ROHRBECK, MD, CHARLES W CENTRE
ROIG, MD, GEORGE M ALLEGHENY
ROITMAN, MD, HARRY B PHILADELPHIA
ROITMAN, MD, SUSAN CHESTER
ROJAS, MD, JOB F PHILADELPHIA
ROJAS, MD, JULIO R LUZERNE
ROJER, MD, CHARLES L MONTGOMERY
ROLING, DANIEL B STUDENT
ROLLE JR, MD, WILLIAM A PHILADELPHIA
ROLLO, MD, DANIEL P LEBANON
ROMAN, MD, STEPHEN J WESTMORELAND
ROMANACE, MD, JEAN P WAYNE/PIKE
ROMANO, MD, JOSEPH M ALLEGHENY
ROMANO, MD, VINCENT E BUCKS
ROMANO JR, MD, MICHAEL T BUCKS
ROMANO-JANA, MD, LOURDES R ERIE
ROMANOFF, MD, DAVID PHILADELPHIA
ROMANOW, MD, PETER W PHILADELPHIA
ROMBERGER JR, MD, JAMES A ALLEGHENY
ROMEIKA, MD, MARY M SCHUYLKILL
ROMEO, RYAN C STUDENT
ROMEO, MD, VICTORIA J CLINTON
ROMIG, MD, RONALD S BERKS
ROMINGER, MD, C JULES CHESTER
ROMMEL, MD, CATHERINE T LANCASTER
ROMMEL, MD, F MICHAEL LANCASTER
ROMY, MD, MAURICE PHILADELPHIA
RONEN, ALON STUDENT
RONEY, MD, T JAMES ALLEGHENY
RONGAUS, MD, WILLIAM J WASHINGTON
RONIS, MD, MAX L PHILADELPHIA
RONKIN, MD, SHEILA L CHESTER
RONNERMANN, MD, DREW P MONTGOMERY
ROODE, MD, ALBERT G VENANGO
ROODE, MD, PHILIP J VENANGO
ROOKLIN, MD, ANTHONY R DELAWARE
ROONEY, MD, DAVID G CHESTER
ROONEY, MD, JOSEPH W BEAVER
ROOS, MD, ALFRED T ERIE
ROOS, MD, LEON ADAMS
ROOT, MD, DOUGLAS C SOMERSET
ROQUIZ, MD, ELISEO M ERIE
RORICK, MD, NICHOLAS R MONTGOMERY
RORKE III, MD, JOHN H CHESTER
ROSA, MD, DEBORAH M CHESTER
ROSALES, MD, GABRIEL B BUCKS
ROSAN, DO, JAY R MONTGOMERY
ROSAN, DO, STUART W BUCKS
ROSARIO JR, MD, ELISEO CUMBERLAND
ROSATO, MD, DONALD J CHESTER
ROSATO, MD, ERNEST F PHILADELPHIA
ROSATO, MD, FRANCIS E PHILADELPHIA
ROSCH, MD, JULIUS C BLAIR
ROSCHEL, MD, ROBERT L LANCASTER
ROSCOE, MD, CONSTANTINE PHILADELPHIA
ROSE, BRUCE T STUDENT
ROSE, MD, CAROL E ALLEGHENY
ROSE, MD, DAVID MONTGOMERY
ROSE, MD, DAVID I PHILADELPHIA
ROSE, DOUGLAS J STUDENT
ROSE, MD, ELIZABETH K PHILADELPHIA
ROSE, MD, GILBERT M DELAWARE
ROSE, HARRY J STUDENT
ROSE, MD, HENRY S PHILADELPHIA
ROSE, MD, JOEL E DAUPHIN
ROSE, MD, LESLIE I PHILADELPHIA
ROSE, MD, LEWIS J PHILADELPHIA
ROSE, MD, ROBERT M MONTGOMERY
ROSEFSKY, MD, JONATHAN B MONTGOMERY
ROSEMAN, MD, RICHARD L DELAWARE
ROSEMOND, MD, GEORGE P PHILADELPHIA
ROSEN, MD, BRUCE J DELAWARE
ROSEN, MD, DANIEL H VENANGO
ROSEN, MD, DAVID PHILADELPHIA
ROSEN, MD, DAVID PHILADELPHIA
ROSEN, MD, ILENE M PHILADELPHIA
ROSEN, MD, JOSEPH H PHILADELPHIA
ROSEN, MD, LEONARD DELAWARE
ROSEN, MD, LESTER LEHIGH
ROSEN, MD, MARC R PHILADELPHIA
ROSEN, MD, MARVIN I PHILADELPHIA
ROSEN, MD, RANDY A LEHIGH
ROSEN, MD, SCOTT I NORTHAMPTON
ROSEN, MD, SHARON I STUDENT
ROSENAU, DO, ALEXANDER M LEHIGH
ROSENBACH, MD, LOREN M ALLEGHENY
ROSENBAUM, MD, ARMAND L PHILADELPHIA
ROSENBAUM, MD, ARON CAMBRIA
ROSENBAUM, MD, CARL A PHILADELPHIA
ROSENBAUM, MD, JOEL N LYCOMING
ROSENBERG, MD, FRANK DELAWARE
ROSENBERG, MD, HENRIETTA K PHILADELPHIA
ROSENBERG, MD, HENRY PHILADELPHIA
ROSENBERG, MD, HOWARD D LEHIGH
ROSENBERG, MD, IRVING PHILADELPHIA
ROSENBERG, MD, JENNIFER T ALLEGHENY
ROSENBERG, MD, KENNETH C PHILADELPHIA
ROSENBERG, MD, LAWRENCE S CAMBRIA
ROSENBERG, MD, MANUEL PHILADELPHIA
ROSENBERG, MD, MORTON PHILADELPHIA
ROSENBERG, MD, PAUL E PHILADELPHIA
ROSENBERG, MD, PHILIP MONTGOMERY
ROSENBERG, MD, RANDY M PHILADELPHIA
ROSENBERG, MD, ROBIN E PHILADELPHIA
ROSENBLATT, MD, STANLEY G CAMBRIA
ROSENBLOOM, MD, MEYER A ALLEGHENY
ROSENBLOOM, MD, RICHARD C ALLEGHENY
ROSENBLOOM, MD, STANLEY E ALLEGHENY
ROSENBLUM, MD, FRED A MONTGOMERY
ROSENBLUM, MD, MINDY F PHILADELPHIA
ROSENBLUM, MD, NORMAN G PHILADELPHIA
ROSENCRANS, MD, DAVID L ALLEGHENY
ROSENCRANTZ, MD, ELLIOT BLAIR
ROSENFELD, MD, BERNARD D LACKAWANNA
ROSENFELD, MD, DAVID J LANCASTER
ROSENFELD, MD, JOEL C NORTHAMPTON
ROSENFELD, MD, PHILIP A MONTGOMERY
ROSENFELD, MD, RICHARD N MONTGOMERY
ROSENFELD, DO, RONALD N DELAWARE
ROSENMAN, MD, HOWARD D BUCKS
ROSENOW JR, MD, EDWARD C PHILADELPHIA
ROSENSTEIN, MD, MAURY M ALLEGHENY
ROSENSWEIG, MD, WILLIAM LUZERNE
ROSENTHAL, MD, DAVID E PHILADELPHIA
ROSENTHAL, MD, MARK E MONTGOMERY
ROSENTHAL, MD, PHILIP PHILADELPHIA
ROSENTHAL, MD, STEPHEN I LACKAWANNA
ROSENWASSER, MD, ROBERT H PHILADELPHIA
ROSENZWEIG, MD, ANDREW S ALLEGHENY
ROSENZWEIG, MD, MAX PHILADELPHIA
ROSENZWEIG, MD, SETH E BERKS
ROSETT, MD, JEFFREY S PHILADELPHIA
ROSIECKI, MD, MICHAEL W LACKAWANNA
ROSIN, MD, DEBORAH F PHILADELPHIA
ROSKA, MD, JOSE C COLUMBIA
ROSKIN, ROBERT E STUDENT

ROSKO, MD, THOMAS J	BUCKS
ROSKOS, MD, STEVEN E	STUDENT
ROSNER, MD, ISADOR K	PHILADELPHIA
ROSNER, MD, MICHAEL J	MONTGOMERY
ROSS, MD, ABRAHAM	LEHIGH
ROSS, MD, DANIEL I	LEHIGH
ROSS, MD, DAVID S	LEHIGH
ROSS, MD, DENISE H	PHILADELPHIA
ROSS, MD, GARY W	LACKAWANNA
ROSS, DO, JOYCE I	BUCKS
ROSS, MD, PATRICIA E	CHESTER
ROSS, MD, R DOUGLAS	PHILADELPHIA
ROSS, MD, VINCENT L	LACKAWANNA
ROSS, MD, WILLIAM M	BUCKS
ROSSBERG, MD, MARK I	PHILADELPHIA
ROSSI, MD, JOHN A	DAUPHIN
ROSSI, MD, JOHN C	ALLEGHENY
ROSSI, MD, MICHAEL A	LEHIGH
ROSSI JR, MD, RALPH A	CHESTER
ROSSMAN, MD, MAX	LEHIGH
ROSSMAN, MD, RONALD E	PHILADELPHIA
ROST, MD, CHARLES R	LANCASTER
ROST, MD, KAY S	WESTMORELAND
ROSTOCK, MD, ROBERT A	LUZERNE
ROSVANIS, MD, THOMAS K	ALLEGHENY
ROTCHE, MD, ROBERT M	DELAWARE
ROTENBERG, MD, LARRY A	BERKS
ROTH, MD, JAMES L	PHILADELPHIA
ROTH, MD, JERRY M	BUCKS
ROTH, MD, JONATHAN V	PHILADELPHIA
ROTH, MD, KATALIN E	PHILADELPHIA
ROTH, MD, LOREN H	ALLEGHENY
ROTH, DO, MICHAEL A	MERCER
ROTH, DO, RAYMOND D	UNION
ROTH, MD, RUSSELL B	ERIE
ROTH, MD, THOMAS G	WESTMORELAND
ROTH, MD, TONI C	PHILADELPHIA
ROTH JR, MD, GEORGE R	DAUPHIN
ROTHACKER JR, MD, GERALD W	LANCASTER
ROTHENBERG, MD, MITCHELL H	ALLEGHENY
ROTHENBERGER, MD, MARVIN K	LEHIGH
ROTHENBERGER, MD, RODGER F	CHESTER
ROTHERMEL, MD, FRANKLIN J	MONTOUR
ROTHERMEL II, DO, ROBERT E	YORK
ROTHKOPF, MD, BRAD M	PHILADELPHIA
ROTHKOPF, MD, HENRY	PHILADELPHIA
ROTHMAN, MD, DAVID L	ALLEGHENY
ROTHMAN, MD, DAVID L	MERCER
ROTHMAN, MD, KEITH S	BUCKS
ROTHMAN, MD, RICHARD H	PHILADELPHIA
ROTHROCK, CHRISTOPHER R	STUDENT
ROTHROCK, MD, GILMORE M	YORK
ROTHSCHILD, MD, JEFFREY M	ALLEGHENY
ROTHSCHILD, MD, JOHN A	LUZERNE
ROTHSTEIN, MD, EDWARD P	BUCKS
ROTHSTEIN-RUBIN, MD, RENE	PHILADELPHIA
ROTOR-MAKILAN, MD, MARILYN L	LANCASTER
ROTTENBERG, DO, LOUIS	PHILADELPHIA
ROTTSCHAEFER, MD, BERNARD L	WESTMORELAND
ROUMM, MD, ALAN D	DAUPHIN
ROUSE, MD, PAUL V	PHILADELPHIA
ROUSH JR, MD, ROBERT K	DELAWARE
ROUSSEL, MD, PAULA L	DAUPHIN
ROVINSKI, MD, HELEN T	LEBANON
ROVINSKY, DAVID	STUDENT
ROVITO, MD, PETER F	LEHIGH
ROWAN, MD, BRUCE W	BEAVER
ROWAN, MD, PAUL J	LANCASTER
ROWAN, MD, PHILIP T	PHILADELPHIA
ROWAN, MD, SANDRA K	BERKS
ROWAND, MD, RANDALL W	YORK
ROWANE, DO, MICHAEL P	ERIE
ROWE, MD, LEE D	PHILADELPHIA
ROWE, MD, MARC I	ALLEGHENY
ROWE JR, MD, KENNETH W	CAMBRIA
ROWEHL, MD, JANE B	DAUPHIN
ROWLAND, MD, HAROLD A	MONTGOMERY
ROWLAND III, MD, PAUL L	ALLEGHENY
ROWLEY, MD, RICHARD S	CHESTER
ROWMAN, MD, LEO	PHILADELPHIA
ROXBY, MD, BRUCE S	PHILADELPHIA
ROY, MD, DIPANWITA	PHILADELPHIA
ROY, MD, JOHN	PHILADELPHIA
ROY, MD, PRAVEEN K	PHILADELPHIA
ROY III, MD, EMILE P	CENTRE
ROYAL, MD, DAVID R	CUMBERLAND
ROYAL, MD, MIKE A	ALLEGHENY
ROYER, CHRISTIAN T	STUDENT
ROZANSKI, MD, STANLEY J	BERKS
ROZANSKI JR, MD, LAWRENCE T	PHILADELPHIA
ROZIN, MD, LEON	ALLEGHENY
ROZWADOWSKI, MD, JACK V	ERIE
RUBASH, MD, HARRY E	ALLEGHENY
RUBBO, MD, ERNEST R	DAUPHIN
RUBEN, MD, JEROLD R	WASHINGTON
RUBEN, MD, MALCOLM E	WASHINGTON
RUBENFIELD, MD, ARNOLD D	ALLEGHENY
RUBENSTEIN, MD, DAVID L	DELAWARE
RUBENSTEIN, MD, MORTON J	DAUPHIN
RUBENSTONE, MD, JEANNE C	CHESTER
RUBIN, DO, CARL S	PHILADELPHIA
RUBIN, MD, EMANUEL	PHILADELPHIA
RUBIN, MD, EMMA	LACKAWANNA
RUBIN, MD, FRED H	ALLEGHENY
RUBIN, MD, HARVEY M	ALLEGHENY
RUBIN, MD, I EDWARD	PHILADELPHIA
RUBIN, MD, JEFFRY F	MONTGOMERY
RUBIN, MD, JONATHAN D	PHILADELPHIA
RUBIN, MD, JOYCE R	PHILADELPHIA
RUBIN, MD, LORE R	ALLEGHENY
RUBIN, DO, MORTON	DELAWARE
RUBIN, MD, MORTON L	DAUPHIN
RUBIN, MD, PETER E	MONTGOMERY
RUBIN, MD, WALTER	PHILADELPHIA
RUBIN-DE CELIS, MD, CARLOS	PHILADELPHIA
RUBINO, MD, MARK A	ALLEGHENY
RUBINSON, ERIK S	STUDENT
RUBINSTEIN, MD, DEBRA N	ALLEGHENY
RUBRIGHT, MD, GEORGE L	BERKS
RUBY, MD, EDWARD B	DELAWARE
RUDDEN, MD, ANN	BUCKS
RUDDY, MD, PATRICK J	PHILADELPHIA
RUDIN, MD, JENNIFER E	ALLEGHENY
RUDLEY, MD, LLOYD D	PHILADELPHIA
RUDMAN, MD, RICHARD	ALLEGHENY
RUDNICK, MD, HERMAN D	PHILADELPHIA
RUDNICK, MD, JON	ALLEGHENY
RUDNITZKY, MD, JEROME	DELAWARE
RUDOLPH, JEFFREY A	STUDENT
RUDOLPH, MD, JOSEPH	PHILADELPHIA
RUDOLPH, MD, JOSEPH P	ALLEGHENY
RUDOLPH, MD, KENNETH H	LACKAWANNA
RUDOLPH, MD, ROBERT I	BERKS
RUDOLPH JR, MD, SAMUEL F	MONTGOMERY
RUDUSKY, MD, BASIL M	LUZERNE
RUDZINSKI, MD, AMY J	PHILADELPHIA
RUEBEL, MD, ARMIN A	BUCKS
RUEGER, MD, RAIMUND G	ALLEGHENY
RUEHL, MD, WILLIAM W	WASHINGTON
RUETSCHI, MD, MAJA S	UNION
RUFE, MD, REDDING H	BUCKS
RUFF, MD, CURTIS C	BUTLER
RUFFER, MD, JAMES E	PHILADELPHIA
RUFFINI, MD, JOHN A	DELAWARE
RUFFINI, MD, JOHN J	DELAWARE
RUFFLE, MD, JOAN M	DAUPHIN
RUFFNER, MD, ROBERT J	ALLEGHENY
RUGART, MD, KARL F	PHILADELPHIA
RUGEL, MD, STANLEY J	PHILADELPHIA
RUGGIERO, DO, DOMINIC	LACKAWANNA
RUGGIERO, MD, NICHOLAS J	LUZERNE
RUGGIERO, MD, ROBERT A	CHESTER
RUGGLES, CRAIG S	STUDENT
RUHT, MD, BARRY A	LEHIGH
RUIZ, MD, CESAR A	ALLEGHENY
RUIZ, MD, VICTOR H	ALLEGHENY
RULIN, MD, MARVIN C	ALLEGHENY
RUMBAUGH, MD, MARSHALL U	LUZERNE
RUMBAUGH, MD, ROSS S	SOMERSET
RUMBAUGH JR, MD, JAMES O	PERRY
RUMBLE, MD, THOMAS R	ALLEGHENY
RUMSEY, MD, WILLIAM P	DELAWARE
RUNCO, MD, ANGELO S	ALLEGHENY
RUNDORFF, MD, ROBERT L	CAMBRIA
RUNK, MD, LORENZO G	PHILADELPHIA
RUNYAN, DO, JOHN L	COLUMBIA
RUOCCO, MD, MARTIN J	FRANKLIN
RUPP, MD, MICHAEL J	FRANKLIN
RUPP, MD, ROBERT A	FAYETTE
RUSCHAK, MD, PAUL J	ALLEGHENY
RUSCZYK, GREGG E	STUDENT
RUSH, MD, CALVIN C	GREENE
RUSH, MD, JOHN F	FAYETTE
RUSIN, MD, LAWRENCE C	ERIE
RUSLI, MD, MICHAEL	LEBANON
RUSS, DO, SHERYL A	MONTOUR
RUSSAVAGE, MD, JAMES M	ALLEGHENY
RUSSEK, MD, EDWARD	DAUPHIN
RUSSELL, MD, JOHN A H	YORK
RUSSELL, MD, JOHN J	MONTGOMERY
RUSSELL, MD, KAMAL B	DELAWARE
RUSSELL, MD, MARIE O	DELAWARE
RUSSELL JR, MD, BERTRAM R	CHESTER
RUSSIN, MD, MARY S	UNION
RUSSINO, MD, JOSEPH L	DELAWARE
RUSSINOVICH, MD, NICHOLAS A E	ALLEGHENY
RUSSMAN, MD, RICHARD B	ALLEGHENY
RUSSO, MD, ANTHONY F	LANCASTER
RUSSO, MD, DAVID P	HUNTINGDON
RUSSO, MD, JOHN F	SCHUYLKILL
RUSSO, MD, JOSEPH F	ALLEGHENY
RUSSO, MD, JOSEPH R	WAYNE/PIKE
RUSSO, MD, KATHLEEN	STUDENT
RUSSO, MD, MICHAEL P	YORK
RUSSO, MD, PIERANTONIO	PHILADELPHIA
RUSSO JR, DO, ANTHONY P	ERIE
RUSSO-STIEGLITZ, MD, KAREN E	PHILADELPHIA
RUTBERG, MD, FRANKLIN L	PHILADELPHIA
RUTBERG, MD, MICHAEL	PHILADELPHIA
RUTENBERG, MD, HAROLD L	PHILADELPHIA
RUTH, MD, COREY K	PHILADELPHIA
RUTH, MD, D HENRY	BEAVER
RUTH, DO, SHAWN R	MONTGOMERY
RUTH, MD, THOMAS K	LANCASTER
RUTHARDT JR, MD, FREDERICK W	FAYETTE
RUTKOSKI, MD, PAMELA H	LYCOMING
RUTLAND, MD, HEDLEY E	YORK
RUTMAN, MD, DEANNA L	ALLEGHENY
RUTSTEIN, MD, RICHARD M	PHILADELPHIA
RUTT, MD, JOHN M	LANCASTER
RUTT JR, MD, CLARENCE H	LANCASTER
RUTTENBERG, MD, BERTRAM A	PHILADELPHIA
RUTTENBERG, DO, NORMAN F	PHILADELPHIA
RUZBARSKY, MD, JOSEPH J	LACKAWANNA
RUZICZKA, MD, LINDA A	ALLEGHENY
RYAN, MD, JOHN J	NORTHAMPTON
RYAN, MD, JOHN L	PHILADELPHIA
RYAN, MD, KATHLEEN F	PHILADELPHIA
RYAN, MD, LAWRENCE W	MONTGOMERY
RYAN, MD, MARILYN	DELAWARE
RYAN, DO, MICHAEL M	YORK
RYAN, MD, WILLIAM C	SOMERSET
RYAN, MD, WILLIAM F	MONROE
RYAN JR, DO, EDWARD F	DELAWARE
RYBARCZYK, MD, RICHARD M	LANCASTER
RYCHAK, MD, JOHN S	DAUPHIN
RYCHIK, MD, JACOB	PHILADELPHIA
RYCKMAN, MD, WILLIAM F	WESTMORELAND
RYCZAK, MD, MARY	LACKAWANNA
RYDQUIST-WHITE, JILL E	STUDENT
RYDZE, MD, RICHARD A	ALLEGHENY
RYDZE, MD, ROBERT A	ALLEGHENY
RYLKO, MD, PATRICIA	MONROE
RYMER, MD, DAVID B	ALLEGHENY
RYNIER, MD, DONALD L	LANCASTER
RYOO, MD, IN O	ALLEGHENY
RYSCAVAGE, MD, THOMAS S	YORK

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SAADAT, MD, MOHAMMAD J	BRADFORD
SAAVEDRA, MD, DIOGENES A	CRAWFORD
SABATELLE, MD, ROBERT C	ALLEGHENY
SABEH, MD, GEORGE	ALLEGHENY
SABEH, MD, RAIF K	ALLEGHENY
SABILI, MD, ERLINDA A	PHILADELPHIA
SABLOSKY, MD, LESTER	MONTGOMERY
SABO, MD, ROBERT P	WESTMORELAND
SABOKBAR, MD, NASSER	MONTGOMERY
SABOL, MD, CAROLYN L	PHILADELPHIA
SABOL, MD, JOHN B	CUMBERLAND
SABOL, MD, LOUISE J	MONTOUR
SABRI, MD, PHILIP J	FRANKLIN
SABUGO, MD, EVELYN F	PHILADELPHIA
SACCO, MD, RUSSELL J	ALLEGHENY
SACHAKUL, MD, CHITRINEE	WESTMORELAND
SACHAROK, MD, CYNTHIA A	DELAWARE
SACHDEV, MD, RANJAN	NORTHAMPTON
SACHDEVA, MD, AJIT K	PHILADELPHIA
SACHDEVA, MD, RAVINDRA K	MERCER
SACHS, MD, MARVIN L	PHILADELPHIA
SACHS, MD, MURRAY	ALLEGHENY
SACKMAN, MD, IRA	DAUPHIN
SACKS, MD, DAVID	BERKS
SACKS, MD, EDMOND J	CHESTER
SACKS, MD, RICHARD P	LEBANON
SACKS, DO, STEPHEN E	MONTGOMERY
SADEL, KEITH E	STUDENT
SADKA, MD, GEORGE M	CLINTON
SADLER, MD, JOHN M	ALLEGHENY
SADOFF, MD, ROBERT L	MONTGOMERY
SADR, MD, FARROKH S	LEHIGH
SADWIN, MD, ARNOLD	PHILADELPHIA
SAFABAKHSH, NAHEED	STUDENT
SAFABAKHSH, MD, SAIED	PHILADELPHIA
SAFDAR, MD, AAMIR	PHILADELPHIA
SAFFORD, SHAWN D	STUDENT
SAFIER, MD, JOEL	ALLEGHENY
SAFINA, DO, THOMAS E	PHILADELPHIA
SAFYAN, MD, ERIC L	ALLEGHENY
SAFYAN, MD, SUSAN L	ALLEGHENY
SAGALOW, MD, BARRY R	PHILADELPHIA
SAGAN, MD, ELIZABETH R	ALLEGHENY
SAGEL, DO, HENRY K	YORK
SAGEMAN, MD, MARC S	PHILADELPHIA
SAGER, MD, ETHEL	PHILADELPHIA
SAGER, DO, MARSHALL H	MONTGOMERY
SAGHAFI, MD, DARIUS	WESTMORELAND
SAHL, MD, HENRY G	PHILADELPHIA
SAHLANEY, MD, WILLIAM J	CAMBRIA
SAHLOLBEI, MD, HOSSAIN	YORK
SAHNI, MD, RITU	ALLEGHENY
SAHOO, MD, DILLISWAR	SCHUYLKILL
SAHOO, MD, KASHINATH	BERKS
SAHOVEY, MD, JAMES R	ALLEGHENY
SAIDMAN, MD, BRUCE H	LUZERNE
SAIDMAN, MD, LESTER M	LUZERNE
SAIF, MD, NAHEED F	LEBANON
SAIFEE, MD, KUTUB M	ALLEGHENY
SAINI, MD, SUNIL K	PHILADELPHIA
SAITO, NAOYUKI G	STUDENT
SAJJADIAN, MD, ALI	PHILADELPHIA
SAKACH, MD, VALERIE A	WASHINGTON
SAKKAL, MD, SAAD	MERCER
SAKOL, MD, PETER J	BERKS
SAKOLSKY, DARA J	STUDENT
SALADA, MD, ELIZABETH A P	DAUPHIN
SALAK, MD, WASYL W	PHILADELPHIA
SALAM, MD, MAHI	CHESTER
SALAND, MD, DAVID K	DELAWARE
SALAS, MD, MARTY M	CAMBRIA
SALATKA, MD, KARL W	WESTMORELAND
SALAZAR, MD, EDGARDO P	CARBON
SALAZAR, MD, LOUIS F	YORK
SALAZAR, MD, PEDRO A	LUZERNE
SALCEDO, MD, WILFREDO G	NORTHAMPTON
SALDANA, MD, IDEL J	JEFFERSON
SALEEM, MD, MOHAMMAD A	LACKAWANNA
SALEH, MD, A NABIL	PHILADELPHIA
SALEHI, HASSAN A	STUDENT
SALERNO, MD, DENISE A	PHILADELPHIA
SALES, MD, IRVING J	PHILADELPHIA
SALES, MD, PHOENIX M	PHILADELPHIA
SALGADO, MD, EDWARD M	NORTHAMPTON
SALILENG, MD, FILEMON F	BERKS
SALINDONG, MD, JAIME P	MONTGOMERY
SALKIND, MD, GARY D	DELAWARE
SALKIND, MD, GENE Z	PHILADELPHIA
SALLASH JR, MD, ROBERT J	NORTHAMPTON
SALMON, MD, JAMES H	ERIE
SALNER, MD, NATHAN P	PHILADELPHIA
SALOKY, DO, PAUL A	COLUMBIA
SALOMON, MD, ALEXANDER R	MONTGOMERY
SALOMON, MD, MICHAEL A	WESTMORELAND
SALOWE, MD, DAVID R	BUCKS
SALTZBURG, DO, MICHAEL C	BLAIR
SALTZER, KAREN R	STUDENT
SALTZMAN, MD, LEONARD D	ALLEGHENY
SALTZMAN, MD, MARCUS B	PHILADELPHIA
SALVAGE, MD, ROBERT H	PHILADELPHIA
SALVATORE, MD, DONALD E	PHILADELPHIA
SALVITTI, MD, E RONALD	WASHINGTON
SALVO, MD, PAUL J	PHILADELPHIA
SALVOZA, MD, MANUEL I	ALLEGHENY
SALZANO, LAURA J	STUDENT
SALZMAN, DO, GARY R	PHILADELPHIA
SAMAD, MD, MOHAMMAD A	NORTHMBRLAND
SAMADANI, MD, SIROOS R	ALLEGHENY
SAMAHA JR, MD, A MICHAEL	MONTGOMERY
SAMARASINGHE, MD, GUNASIRI	ERIE
SAMBERG, DO, GARY A	LANCASTER
SAMELSON, MD, LEO	YORK
SAMET, MD, SHERWOOD L	MONROE
SAMHOURI, MD, FAROUQ A	PHILADELPHIA
SAMIES, MD, JOHN H	LEHIGH
SAMII, MD, ABOOL H	LUZERNE
SAMII, MD, ALI M	CAMBRIA
SAMITT, DO, JOEL L	LANCASTER
SAMKOFF, MD, JUDITH S	DAUPHIN
SAMM, PAUL L	STUDENT
SAMMOUR, MD, ADNAN K	LACKAWANNA
SAMPATH, MD, KRISHNA	PHILADELPHIA
SAMPATHACHAR, MD, KAKKADASAM R	PHILADELPHIA
SAMUELS, MD, PAULINE M	PHILADELPHIA
SAMUELS, MD, TODD L	DAUPHIN
SAMUELSEN, MD, THOMAS S	LACKAWANNA
SAMUELSON, MD, JOEL S	MONROE
SANCHEZ, MD, GILBERTO	LUZERNE
SAND, MD, VIJAICHAND S	ELK/CAMERON
SANDBERG, MD, THEODORE E	ALLEGHENY
SANDERS, MD, MARK H	ALLEGHENY
SANDERS, MD, MELINDA E	STUDENT
SANDERS, MD, RICHARD D	ALLEGHENY
SANDERS, MD, ROBERT E	WESTMORELAND
SANDERSON, MD, DOUGLAS K	DAUPHIN
SANDERSON, MD, VINCENT A	MERCER
SANDHAUS, MD, JULIUS L	LANCASTER
SANDHU, MD, BAKHSHISH S	BUCKS
SANDHU, MD, RAJINDER S	ALLEGHENY
SANDHU, MD, RAVNEET K	MONTGOMERY
SANDLER, MD, KENNETH R	CHESTER
SANDLER, LEONARD L	STUDENT
SANDLER, MD, MATTHEW J	PHILADELPHIA
SANDLER, MD, SUSAN M	MONTGOMERY
SANDO, MD, RALPH S	PHILADELPHIA
SANDOVAL, MD, CONCHITA Q	WESTMORELAND
SANDOVAL-BARRETT, MD, JESSY C	PHILADELPHIA
SANDS, MD, EARL E	MONTGOMERY
SANDS, MD, JEFFREY J	LUZERNE
SANDS, DO, SETH C	MONTGOMERY
SANDSON, MD, GERALD B	ALLEGHENY
SANDSTROM, MD, PAUL H	ERIE
SANDSTROM JR, MD, FRANK T	MONTGOMERY
SANFORD, MD, ROBERT G	DAUPHIN
SANG, MD, ELENA	MONTGOMERY
SANGHI, MD, JODH K	WARREN
SANGILLO, MD, CATHLEEN K	DAUPHIN
SANGILLO, MD, MARIO M	DAUPHIN
SANGODEYI, MD, OLU R	ALLEGHENY
SANGRIGOLI, MD, RENEE A	PHILADELPHIA
SANGRUJEE, MD, KANNIKA L	ALLEGHENY
SANGRUJEE, MD, WEERASAK	ALLEGHENY
SANKAR, MD, NAGANATHAN S	BEAVER
SANKARAN, MD, MANICKAM	BLAIR
SANKARI, MD, MUHAMMED A	MCKEAN
SANSONE, MD, THOMAS C	MONTGOMERY
SANSTEAD, MD, JOHN K	YORK
SANT RAM, MD, DEEPAK	CHESTER
SANTA MARIA II, RICHARD G	STUDENT
SANTAMARIA, MD, FRANK R	WESTMORELAND
SANTANGELO, MD, MARSHA F	PHILADELPHIA
SANTANGELO, MD, SAMUEL C	MONTGOMERY
SANTARELLI, DO, ROCCO J	MONTGOMERY
SANTIAGO, MD, EVELYN	BLAIR
SANTIAGO, MD, JOSE W	MERCER
SANTIESTEBAN, MD, JOSEPH A	ALLEGHENY
SANTILLAN, MD, VICTOR H	BLAIR
SANTILLI, MD, THOMAS F	PHILADELPHIA
SANTMAN, MARK	STUDENT
SANTO, MD, JEAN L	DAUPHIN
SANTOMENNA, MD, MICHAEL A	ERIE
SANTOPOLO, MD, ANTHONY C	DELAWARE
SANTORA, MD, ROBERT A	CRAWFORD
SANTORA, MD, THOMAS A	PHILADELPHIA
SANTORA JR, MD, DONALD C	ALLEGHENY
SANTORA JR, MD, FRANK J	ALLEGHENY
SANTORE, MD, FELICE J	DELAWARE
SANTORE, MD, LOUIS X	MONTGOMERY
SANTORO, MD, JEROME	PHILADELPHIA
SANTORO, MD, WILLIAM	BERKS
SANTOS, MD, ARTHUR M	ALLEGHENY
SANTOS, MD, CESAR R	LAWRENCE
SANTOS, MD, EDWIN M	NORTHAMPTON
SANTOS, MD, LEONOR	INDIANA
SANTOS, MD, RODOLFO J	BUCKS

SANTOS, MD, RODOLFO R	SOMERSET
SANTOS-DAY, MD, JACQUELINE	ALLEGHENY
SANTOSO, MD, LIMJADI	ERIE
SANTUCCI, MD, FRANCESCO	ALLEGHENY
SAPIRA, MD, VALDI	MONTGOMERY
SAPONARO, MD, STEPHEN A	PHILADELPHIA
SAPORITO, MD, J JUSTIN	ALLEGHENY
SAPPERSTEIN, SCOTT B	STUDENT
SAQUIN, MD, RAINELDO C	MCKEAN
SARAC, MD, ERDAL S	BEAVER
SARACCO, MD, THOMAS R	ALLEGHENY
SARACHEK, MD, NORMAN S	LEHIGH
SARACINO, MD, DINO P	BEDFORD
SARADAR, MD, RAJA	ALLEGHENY
SARADAR, MD, RIAD	FAYETTE
SARAFIAN, STEPHEN R	STUDENT
SARAGOVI, MD, ARMAND A	PHILADELPHIA
SARAJEDINI, MD, HOSSAIN	MCKEAN
SARAN, MD, MADHUKAR	SUSQUEHANNA
SARAS, MD, HARRY P	MONROE
SARAS, MD, PETER L	LUZERNE
SARBAK, JOHN M	STUDENT
SARDESAI, MD, PRABHAKER G	ERIE
SARGE, MD, TERENCE J	FRANKLIN
SARGENT, MD, STEPHEN E	BUTLER
SARGINGER, MD, LARRY J	ELK/CAMERON
SARIEGO, MD, JOAQUIN	PHILADELPHIA
SARIN, MD, LOV K	PHILADELPHIA
SARIS, MD, ANNE L	MONTGOMERY
SARIS, MD, DEMETRIUS S	MONTGOMERY
SARIS-MECHENBIER, MD, LYDIA E	ALLEGHENY
SARISKY-MELOY, DO, STEPHANIE	MONTOUR
SARKAR, MD, SHYAMAL	PHILADELPHIA
SARKER, MD, CHITTA R	MONTGOMERY
SARKESSIAN, DO, ALBERT M	PHILADELPHIA
SARMA, MD, SATYA	ALLEGHENY
SARMA, MD, SHASHIKALA	ALLEGHENY
SARNER, MD, JOEL B	ALLEGHENY
SARNOWSKI, MD, ROBERT J	LACKAWANNA
SARSHIK, MD, MILTON	PHILADELPHIA
SARTSCHEV, MD, CAROLINE A	ALLEGHENY
SARUBIN, MD, DANIEL R	LEHIGH
SARUK, MD, MICHAEL L	CHESTER
SARVER, MD, RAY G	WESTMORELAND
SARVER, MD, ROBERT O	ALLEGHENY
SASSANI, MD, JOSEPH W	DAUPHIN
SASSO, MD, PHILIP J	PHILADELPHIA
SATALOFF, MD, DAHLIA M	PHILADELPHIA
SATALOFF, MD, JOSEPH	PHILADELPHIA
SATALOFF, MD, ROBERT T	PHILADELPHIA
SATCHELL, JACQUELINE R	STUDENT
SATINSKY, MD, JONATHAN D	DELAWARE
SATO, MD, TAKAMI	PHILADELPHIA
SATRIALE, MD, ROBERT O	CHESTER
SATTERLY, CLYDE H	STUDENT
SATYAM, MD, BHAGYALAKSHMI D	LUZERNE
SAUCO, MD, M CONCEPCION	PHILADELPHIA
SAUER, MD, DIETER	WESTMORELAND
SAUER, MD, GARY G	ALLEGHENY
SAUER, MD, THOMAS S	NORTHAMPTON
SAUL, MD, ALBERT	PHILADELPHIA
SAUL, MD, LEON J	PHILADELPHIA
SAULL, MD, SONDRA C	PHILADELPHIA
SAUNDERS, MD, CATHY L	WESTMORELAND
SAUNDERS, MD, CHARLES D	NORTHAMPTON
SAUNDERS, MD, RICHARD M	MONTGOMERY
SAUNDERSON JR, MD, ROBERT W	LANCASTER
SAUSSER, MD, EUGENE W	CUMBERLAND
SAUTER, MD, JOHN G	MONTGOMERY
SAVACOOL, MD, JACOB W	PHILADELPHIA
SAVAGE, CARRIE A	STUDENT
SAVAGE, MD, DONALD J	LUZERNE
SAVAGE, MD, MICHAEL P	PHILADELPHIA
SAVAGE, MD, PETER J	LUZERNE
SAVINESE, DO, STANLEY J	DELAWARE
SAVINO, MD, PETER J	PHILADELPHIA
SAVIT, MD, RUSS M	PHILADELPHIA
SAWARDEKAR, MD, ARUN S	MERCER
SAWICKI, MD, EDWARD H	INDIANA
SAWIN, MD, HENRY S	MONTGOMERY
SAWYER, MD, JEFFREY R	PHILADELPHIA
SAWYER, MD, MICHAEL A J	PHILADELPHIA
SAXENA, MD, VARUN	BUCKS
SAXON, MD, ANDREA M	DELAWARE
SAXON, MD, JOSEPH G	DAUPHIN
SAYE JR, MD, WILLIAM H	DAUPHIN
SAYEN, MD, JOHN J	PHILADELPHIA
SAYERS, MD, FRANCIS P	NORTHMBRLAND
SAYERS, MD, KENNETH H	INDIANA
SAYLOR, MD, RANDALL M	BUTLER
SAYLOR, MD, RICHARD F	MONTGOMERY
SAYSON, MD, JOSE N	LEBANON
SBARRO, DO, MARK J	LAWRENCE
SBAT, DO, KENNEDY J	MONTGOMERY
SCACHERI, MD, JENNIFER E	PHILADELPHIA
SCACHERI, MD, ROBERT Q	PHILADELPHIA
SCAGLINE, MD, RHONDA L	ERIE
SCAGLIOTTI, MD, CHARLES J	LEHIGH
SCANLIN, MD, THOMAS F	PHILADELPHIA
SCANTLEBURY, MD, VELMA P	ALLEGHENY
SCARAMUCCI, MD, JOHN C	ALLEGHENY
SCARANO, MD, VICTOR R	PHILADELPHIA
SCARITO, MD, ELIZABETH A	YORK
SCARPA, MD, HARRY C	MONTGOMERY
SCARPINO, MD, LEO J	LEHIGH
SCARSELLA, MD, LINDA	DAUPHIN
SCARSELLATO, MD, JOHN N	ALLEGHENY
SCERBO, MD, JAMES A	JEFFERSON
SCHAAF, MD, HOMER D	CHESTER
SCHAAF, MD, JOHN T	ERIE
SCHAAF, MD, RICHARD D	DELAWARE
SCHACHTERLE, MD, RALPH E	LANCASTER
SCHADDER, CYNTHIA A	STUDENT
SCHADT, MD, DANIEL C	NORTHAMPTON
SCHADT, MD, MARK E	NORTHAMPTON
SCHAEBLER, MD, M LEE	BERKS
SCHAEFER, MD, DAVID C	YORK
SCHAEFER, MD, KATHLEEN A	CLEARFIELD
SCHAEFER, MD, THOMAS L	ALLEGHENY
SCHAEFFER, MD, CHARLES S	CENTRE
SCHAEFFER, MD, WILLIAM A	LANCASTER
SCHAEFFER JR, MD, WILLIAM E	LEBANON
SCHAENEN, MD, WENDY	DAUPHIN
SCHAFER, MD, CHARLES H	PHILADELPHIA
SCHAFFER, MD, DAVID B	PHILADELPHIA
SCHAFFER, MD, DAVID N	DAUPHIN
SCHAFFER, MD, DAVID W	PHILADELPHIA
SCHAFFER, MD, ELLIOTT L	DELAWARE
SCHAFFER, MD, LILLY H	PHILADELPHIA
SCHAINKER, MD, BRUCE A	PHILADELPHIA
SCHALL, MD, JAMES E	HUNTINGDON
SCHALL, MD, ROY F	ALLEGHENY
SCHALLER, MD, JAMES A	MONTGOMERY
SCHALLER, MD, JAMES L	PHILADELPHIA
SCHANER, MD, PAUL J	ALLEGHENY
SCHANK, MD, DENNIS J	MONTGOMERY
SCHANTZ, DO, BEVERLY B	LANCASTER
SCHANTZ, MD, JOHN C	LANCASTER
SCHAPIRE, MD, PHYLLIS G	DELAWARE
SCHAPIRO, MD, ROLF L	ALLEGHENY
SCHARF, MD, ANN I	DELAWARE
SCHARF, MD, RENEE D	MONTGOMERY
SCHARLE, MD, W TIMOTHY	NORTHAMPTON
SCHARTEL, DO, ALBERT P	BERKS
SCHATANOFF, MD, DAVID	BLAIR
SCHATANOFF, MD, JOSEPH	PHILADELPHIA
SCHATZ, MD, NORMAN J	PHILADELPHIA
SCHAUB, MD, DAVID H	ALLEGHENY
SCHAUBLE, MD, THOMAS L	ALLEGHENY
SCHEATZLE, MD, MARK D	ALLEGHENY
SCHECKER, MD, NEIL H	PHILADELPHIA
SCHECTER, MD, BENJAMIN C	MONROE
SCHEERS, MD, GEORGE F	LUZERNE
SCHEIB, MD, FREDERICK J	WASHINGTON
SCHEID, MD, EDWARD R	ALLEGHENY
SCHEID, MD, VICKY L	CHESTER
SCHEIN, MD, ALAN L	DAUPHIN
SCHEIN, MD, PHILIP S	MONTGOMERY
SCHEIN, MD, ROBERT A	ALLEGHENY
SCHEIN II, MD, GEORGE	ALLEGHENY
SCHEINER, ADAM J	STUDENT
SCHEINER, MD, JAC D	ALLEGHENY
SCHEINER, MD, ROBIN B	DELAWARE
SCHEINMAN, MD, HAROLD Z	ALLEGHENY
SCHELKUN, MD, P MICHAEL	BUCKS
SCHELL, MD, STEPHEN E	ERIE
SCHELL JR, MD, FRANCIS J	LUZERNE
SCHELLENBERG, MD, JOSEPH B	PHILADELPHIA
SCHENCK, DO, ARTHUR C	ERIE
SCHENCK, DO, DAVID P	ERIE
SCHENCK, MD, PAUL H	LEHIGH
SCHENDEL, MD, PAUL B	YORK
SCHENFELD, MD, LOUIS A	CAMBRIA
SCHENKEL, MD, ERIC J	NORTHAMPTON
SCHER, MD, CHARLES D	PHILADELPHIA
SCHER, MD, DAVID L	DAUPHIN
SCHERER, MD, BERNARD C	WESTMORELAND
SCHERR, MD, STUART A	PHILADELPHIA
SCHEUER, MD, JOHN W	LACKAWANNA
SCHEUERMANN, MD, HENRY A	DELAWARE
SCHIAVONE, MD, JOSEPH A	NORTHAMPTON
SCHIETROMA, MD, JOHN J	DAUPHIN
SCHIFF, MD, MELVIN M	ALLEGHENY
SCHIFFMAN, MD, RAYMOND J	PHILADELPHIA
SCHILLER, MD, HERBERT M	PHILADELPHIA
SCHILLER, MD, RUTH P	BUCKS
SCHILLI, MD, RUDOLPH	CAMBRIA
SCHILLING, MD, JACQUELINE	DELAWARE
SCHILLING, MD, JOHN F	DELAWARE
SCHILLING, MARIA M	STUDENT
SCHIMMER, MD, BARRY M	PHILADELPHIA
SCHINDLER, MD, ALAN M	PHILADELPHIA
SCHINDLER, MD, JOHN T	ALLEGHENY
SCHINDLER, MD, PETER D	CHESTER
SCHINFELD, MD, LOUIS H	MONTGOMERY
SCHIOWITZ, MD, ALBERT	LUZERNE
SCHIOWITZ, MD, MARK F	LUZERNE
SCHIRO, MD, JOHN C	DAUPHIN
SCHLACKMAN, MD, NEIL	BUCKS
SCHLAFF, MD, LILLIAN T	PHILADELPHIA
SCHLAFF, MD, SHELDON	PHILADELPHIA
SCHLAGER, MD, BARBARA A	BUCKS
SCHLAGER, MD, CHARLES E	YORK
SCHLANSKY, MD, RONALD M	CUMBERLAND
SCHLECHTER, MD, MICHAEL J	MONTGOMERY
SCHLEGEL JR, MD, ROBERT J	YORK
SCHLEICHER, MD, STEPHEN M	LUZERNE
SCHLEIFER, MD, CHARLES R	PHILADELPHIA
SCHLERNITZAUER, AMY R	STUDENT
SCHLESINGER, KIMBERLY W	STUDENT
SCHLESINGER, MD, ROBERT B	PHILADELPHIA
SCHLESS, MD, ARTHUR P	CHESTER
SCHLESSEL, MD, RICHARD B	PHILADELPHIA
SCHLEZINGER, MD, NATHAN S	PHILADELPHIA
SCHLICHTING, MD, CHRISTINE M	PHILADELPHIA
SCHLITZER, MD, WILLIAM H	SCHUYLKILL
SCHLOSS, MD, EDWARD J	ALLEGHENY
SCHLOSSBERG, MD, DAVID	PHILADELPHIA
SCHLOSSER, MD, DAVID E	LANCASTER
SCHMALTZ, MD, HARRY W	LACKAWANNA
SCHMELTZ, MD, RALPH	ALLEGHENY
SCHMELTZLE, DO, TIMOTHY C	LEHIGH
SCHMEYER, MD, JON E	YORK
SCHMIDHEISER, MD, MARK A	STUDENT
SCHMIDHOFER, MD, MARK	ALLEGHENY
SCHMIDT, MD, ARNOLD P	LUZERNE
SCHMIDT, MD, COURTLAND M	PHILADELPHIA
SCHMIDT, MD, H WILLIAM	MONTGOMERY
SCHMIDT, MD, RICHARD J	PHILADELPHIA
SCHMIDT, MD, STEPHEN L	BLAIR
SCHMIDT JR, MD, ERWIN R	PHILADELPHIA
SCHMIELER, MD, GEORGE C	WASHINGTON
SCHMITT, MD, CHARLES L	ALLEGHENY
SCHMITT, MD, HERMAN L	ALLEGHENY
SCHMITT, MD, JOHN E	MIFFLIN/JUNIATA
SCHMITT, SUSAN C	STUDENT
SCHMITZ, MD, THOMAS J	ADAMS
SCHMUKLER, DO, ANITA G	PHILADELPHIA
SCHMUTZLER III, MD, ROBERT C	MONTGOMERY
SCHNALL, MD, BARRY	PHILADELPHIA
SCHNALL, MD, CHARLES	PHILADELPHIA
SCHNALL, MD, DAVID J	PHILADELPHIA
SCHNALL, MD, NATHAN	PHILADELPHIA
SCHNAUFER, MD, LOUISE	PHILADELPHIA
SCHNECK JACOB, MD, STEPHANIE L	ALLEGHENY
SCHNEE, MD, SCOTT S	VENANGO
SCHNEEBERG, MD, ARTHUR L	PHILADELPHIA
SCHNEEBERG, MD, NORMAN G	PHILADELPHIA
SCHNEIDER, MD, BARBARA P	ALLEGHENY
SCHNEIDER, MD, BERNARD	PHILADELPHIA
SCHNEIDER, MD, JAN	PHILADELPHIA
SCHNEIDER, MD, JILL	MONTGOMERY
SCHNEIDER, MD, LAWRENCE H	PHILADELPHIA
SCHNEIDER, MD, MICHAEL P	ALLEGHENY
SCHNEIDER, MD, RICHARD R	ALLEGHENY
SCHNEIDER, MD, ROBERT E	ALLEGHENY
SCHNEIDER, MD, ROBERTA L	MONTGOMERY
SCHNEIDERMAN, MD, MARC J	ALLEGHENY
SCHNEIMAN, MD, MAURICE H	PHILADELPHIA
SCHNELL, MD, BRIAN M	LACKAWANNA
SCHNIBBEN, MD, KEVIN M	MONTGOMERY
SCHNUR, MD, RHONDA E	PHILADELPHIA
SCHNURER, MD, CHARLES I	ALLEGHENY
SCHNURER, MD, MARK A	BEAVER
SCHOBER, MD, JUSTINE R	ERIE
SCHOCK, MD, WILLIAM W	HUNTINGDON
SCHOCKER, MD, JACK D	BLAIR
SCHOEL, SUZANNE M	STUDENT
SCHOEMER, MD, PAMELA L	ALLEGHENY
SCHOENFELDER, MD, STEVEN J	UNION
SCHOEPPNER, MD, ERIC	NORTHAMPTON
SCHOEPPNER, MD, GABRIELLE	NORTHAMPTON
SCHOFFSTALL, MD, JOHN M	DELAWARE
SCHOFIELD, MD, JOYCE A	MONTGOMERY
SCHOFIELD, MD, R ALAN	MONTGOMERY
SCHOLL, MD, HARVEY W	MONTGOMERY
SCHOLL JR, MD, HARVEY W	BUCKS
SCHOLLAERT, MD, RICHARD A	ALLEGHENY
SCHONAUER, MD, THOMAS D	YORK
SCHONFELD, MD, MARGERY B	BUCKS
SCHONROCK, MD, KRISTA L	LEHIGH
SCHOPFER, MD, RALPH E	LYCOMING
SCHORR, MD, NEAL A	ALLEGHENY
SCHOTT, MD, C RICHARD	DELAWARE
SCHOWALTER, MD, DONALD R	WESTMORELAND
SCHRACK, DO, SAMUEL E	LYCOMING
SCHRAGGER, MD, ALAN H	LEHIGH
SCHRAMM, MD, CRAIG M	PHILADELPHIA
SCHRAMM, MD, FRANK E	NORTHAMPTON
SCHRAN, MD, ALBERT G	DELAWARE
SCHRAUDENBACH, COOPER C	STUDENT
SCHRECK, MD, FRED M	NORTHMBRLAND
SCHRECKENGAUST, MD, ROBERT H	LACKAWANNA
SCHREIBER, MD, RICHARD	DAUPHIN
SCHREIBER, MD, RICHARD D	LEBANON
SCHREINER, MD, GLENWOOD R	LUZERNE
SCHREINER, MD, MARK S	PHILADELPHIA
SCHRENZEL, MD, STEVEN	DELAWARE
SCHROECKENSTEIN, MD, RICHARD F	CRAWFORD
SCHROEDER, MD, JEROME S	PHILADELPHIA
SCHROEDER, MD, RICHARD D	CAMBRIA
SCHROGIE JR, MD, JOHN J	CHESTER
SCHRYVER, MD, THOMAS E	YORK
SCHUBERT, MD, JOHN J	LANCASTER
SCHUCKER, MD, CHARLES L	HUNTINGDON
SCHUCKER, MD, FORREST A	DAUPHIN
SCHUCKER, MD, JODI L	NORTHAMPTON
SCHUERER, DOUGLAS J E	STUDENT
SCHUESSLER, MD, PAUL W	NORTHAMPTON
SCHULHOFF, MD, JOHN W	ALLEGHENY
SCHULLER, MD, DIANE E	MONTOUR
SCHULMAN, MD, EDWARD S	PHILADELPHIA
SCHULMAN, MD, ELLIOTT A	PHILADELPHIA
SCHULMAN, MD, NORMAN	LUZERNE
SCHULMAN, MD, SETH L	PHILADELPHIA
SCHULTHEIS JR, MD, CARL F	MONTGOMERY
SCHULTZ, MD, CHRISTOPHER F	PHILADELPHIA
SCHULTZ, MD, EDWARD D	BLAIR
SCHULTZ, MD, EDWARD M	ALLEGHENY
SCHULTZ, MD, JULIUS	PHILADELPHIA
SCHULTZ, MD, NEIL R	PHILADELPHIA
SCHULTZ, MD, THEODORE A	WESTMORELAND
SCHULTZE, MD, ROBERT L	STUDENT
SCHULZ, MD, JACOB A	LANCASTER
SCHUMACHER, MD, DAVID L	BEAVER
SCHUMACHER, LINDA A	STUDENT
SCHUMAN, MD, ROBERT A	LACKAWANNA
SCHURICHT, MD, ALAN L	PHILADELPHIA
SCHUSTER, MD, ALBERT H	PHILADELPHIA
SCHUSTER, MD, ALLAN H	ALLEGHENY
SCHUSTER, MD, ROBERT T	CHESTER
SCHUT, MD, LUIS	PHILADELPHIA
SCHUTTE, MD, SHARON L	PHILADELPHIA
SCHWAB, MD, MORTON E	PHILADELPHIA
SCHWAB, MD, ROBERT H	PHILADELPHIA
SCHWABE, MD, KARL G	DELAWARE
SCHWALB, MD, ALLEN J	PHILADELPHIA
SCHWALB, MD, NEIL S	PHILADELPHIA
SCHWAMM, MD, HARRY A	PHILADELPHIA
SCHWARCZ, MD, HARRIET B	MONTGOMERY
SCHWARTZ, MD, ALAN J	PHILADELPHIA
SCHWARTZ, MD, ALEC R	ALLEGHENY
SCHWARTZ, MD, BARRY J	PHILADELPHIA
SCHWARTZ, MD, DANIEL N	ALLEGHENY
SCHWARTZ, MD, DONALD S	CHESTER
SCHWARTZ, MD, ELIAS	PHILADELPHIA
SCHWARTZ, MD, EMANUEL E	PHILADELPHIA
SCHWARTZ, MD, GARY M	DAUPHIN
SCHWARTZ, DO, GERSON	DELAWARE
SCHWARTZ, MD, GORDON F	PHILADELPHIA
SCHWARTZ, MD, HARRY W	PHILADELPHIA
SCHWARTZ, MD, IRA	SCHUYLKILL
SCHWARTZ, MD, JEFFREY H	ALLEGHENY
SCHWARTZ, MD, JOEL D	ALLEGHENY
SCHWARTZ, MD, JOEL L	MONTGOMERY
SCHWARTZ, MD, JONATHAN	WESTMORELAND
SCHWARTZ, MD, LEONARD	ALLEGHENY
SCHWARTZ, MD, LINDEN M	PHILADELPHIA
SCHWARTZ, MD, LOUIS	PHILADELPHIA
SCHWARTZ, MD, M WILLIAM	PHILADELPHIA
SCHWARTZ, MD, MARC L	PHILADELPHIA
SCHWARTZ, MD, MELVIN H	LEHIGH
SCHWARTZ, MD, MICHAEL D	LEHIGH
SCHWARTZ, MD, MILTON A	BUCKS
SCHWARTZ, NADINE	STUDENT
SCHWARTZ, MD, PETER A	BERKS
SCHWARTZ, MD, PETER L	BUCKS
SCHWARTZ, MD, RAYMOND	PHILADELPHIA
SCHWARTZ, MD, RAYMOND B	ALLEGHENY
SCHWARTZ, MD, ROBERT M	ERIE
SCHWARTZ, MD, ROBERT P	PHILADELPHIA
SCHWARTZ, MD, SHELDON M	LYCOMING
SCHWARTZ, MD, STEPHEN L	PHILADELPHIA
SCHWARTZ, MD, STEVEN R	LANCASTER
SCHWARTZMAN, GREGORY J	STUDENT
SCHWARZ, MD, DONALD F	PHILADELPHIA
SCHWARZ, MD, GABRIEL A	PHILADELPHIA
SCHWARZ, MD, RICHARD A	BUCKS
SCHWEIKLE, MD, MARY R	LYCOMING
SCHWEIZER, MD, ROBERT A	DELAWARE
SCHWEIZER, MD, ROBERT R	BERKS
SCHWENDEMAN, MD, LESLIE J	ALLEGHENY
SCHWENTKER, ANDREW E	STUDENT
SCHWENTKER, MD, EDWARDS P	DAUPHIN
SCHWERHA, MD, JOSEPH J	ALLEGHENY
SCHWERIN, MD, WILLIAM F	ALLEGHENY
SCHWIEP, MD, FRANCIS	LEHIGH
SCHWINGE, MD, ELAINE A	LEHIGH
SCHWITER, MD, E JOSEPH	LUZERNE
SCIALLA, MD, SALVATORE J	LACKAWANNA
SCIARA, MD, CHRISTINE	DELAWARE
SCIASCIA, DO, KAREN M	NORTHAMPTON
SCIBETTA, MD, MARIO P	ERIE
SCICCHITANO, MD, DAVID C	NORTHMBRLAND
SCICCHITANO, MD, LEON P	SCHUYLKILL
SCICUTELLA, DO, CAROL J	ALLEGHENY
SCINICO, MD, MARK W	LUZERNE
SCIOSCIA, MD, EUGENE A	ALLEGHENY
SCIOSCIA JR, MD, EUGENE A	ALLEGHENY
SCIUBBA, MD, ROCCO P	DELAWARE
SCIULLI, MD, ROBERT L	ALLEGHENY
SCLABASSI, MD, ROBERT J	ALLEGHENY
SCOBLIONKO, MD, DAVID P	NORTHAMPTON
SCOGLIETTI, MD, VINCENT C	ALLEGHENY
SCOGNO, CHARLES A	STUDENT
SCOLA, DO, FILOMENA M	STUDENT
SCOPELLITI, DEBRA	STUDENT
SCORNAVACCHI JR, MD, JOSEPH M	BERKS
SCORNAVACCHI SR, MD, JOSEPH M	BERKS
SCORZA, MD, LARI M	STUDENT
SCOTT, MD, ALVIN J	LUZERNE
SCOTT, DO, BETH A	MONTGOMERY
SCOTT, DO, CLARENCE A	BRADFORD
SCOTT, MD, DONNA P	DELAWARE
SCOTT, MD, DOROTHY C	ALLEGHENY
SCOTT, MD, DURELLE T	LUZERNE
SCOTT, MD, EARL S	PHILADELPHIA
SCOTT, MD, ELAINE B	ARMSTRONG
SCOTT, MD, H DENMAN	PHILADELPHIA
SCOTT, MD, HENRY	PHILADELPHIA
SCOTT, MD, HOWARD K	ALLEGHENY
SCOTT, MD, J CLIFFORD	CHESTER
SCOTT, MD, JACK A	ALLEGHENY
SCOTT, MD, JOHN H	ALLEGHENY
SCOTT, MD, KELLY L	BRADFORD
SCOTT, KIRBY J	STUDENT
SCOTT, DO, MARK E	DELAWARE
SCOTT, MD, NORMAN E	ALLEGHENY

SCOTT, MD, PHYLLIS B	TIOGA
SCOTT, DO, ROBERT C	LANCASTER
SCOTT, MD, SHARON L	YORK
SCOTT, MD, THOMAS F	ALLEGHENY
SCOTT, MD, THOMAS R	YORK
SCOTT JR, MD, S DAVID	MONTGOMERY
SCOTTI, MD, DANIEL M	PHILADELPHIA
SCOVAZZO, MD, MARY L	ALLEGHENY
SCOVERN, MD, HENRY	BERKS
SCRIBNER, MD, BRENDA C	PHILADELPHIA
SCULLIN III, MD, JOHN P	MERCER
SCULLY, MD, JOHN P	BERKS
SCUTELLA, MD, MICHEAL A	ERIE
SE GALL, MD, JANET S	MERCER
SEAMAN, MD, DAVID E	MIFFLIN/JUNIATA
SEARCY, MD, WILLIAM A	ALLEGHENY
SEARFOSS, MD, ROGER C	WESTMORELAND
SEARS, MD, ALAN J	DELAWARE
SEARS, MD, CAROL D	LEBANON
SEAVER, MARK A	STUDENT
SEBASTIAN, MD, CARMELLA M	LACKAWANNA
SEBASTIAN, MD, EUGENE F	DAUPHIN
SEBASTIANELLI, MD, KENNETH J	LACKAWANNA
SEBASTIANELLI, MD, MARIO J	LACKAWANNA
SEBASTIANELLI, MD, WAYNE J	LACKAWANNA
SECHLER, MD, EDITH W	VENANGO
SECKINGER, MD, RAYMOND P	LEHIGH
SECOSKY, MD, JOSEPH J	ALLEGHENY
SEDA, MD, HECTOR J	BERKS
SEDACCA, MD, PAUL J	PHILADELPHIA
SEDLOVSKY, MD, MICHAEL Z	NORTHMBRLAND
SEDOR, MD, DAVID J	LUZERNE
SEEBER, MD, JOHN J	CAMBRIA
SEECOF, MD, RICHARD M	WESTMORELAND
SEELAUS, MD, JERE F	MONTGOMERY
SEETHARAMA, MD, SUBRAMANI	ALLEGHENY
SEEWALD, MD, TRACY R	ALLEGHENY
SEGAL, MD, ALLAN	BEAVER
SEGAL, MD, BERNARD L	PHILADELPHIA
SEGAL, JODI B	STUDENT
SEGAL, MELISSA A	STUDENT
SEGAL, MD, RICARDO	ALLEGHENY
SEGAL, MD, SCOTT	PHILADELPHIA
SEGAL, MD, STANTON	PHILADELPHIA
SEGARRA, MD, SERGIO	MERCER
SEGEDY, MD, MATTHEW S	STUDENT
SEGRAVE-DALY, MD, STEPHEN L	MONROE
SEGU, MD, SUBRAMANYAM	ERIE
SEID, DERICE P	STUDENT
SEID, MD, JEROME E	ALLEGHENY
SEIDEL, MD, FREDERICK J	DAUPHIN
SEIDEL, MD, HORACE Y	NORTHAMPTON
SEIDERS, MD, ELIZABETH P	ALLEGHENY
SEIDL, MD, DANIEL C	YORK
SEIDLICH, MD, FRANKLIN T	DAUPHIN
SEIDNER, MD, MICHAEL R	MONTGOMERY
SEIFERT, MD, CAROL L	ALLEGHENY
SEIFERT, DO, RAYMOND D	ALLEGHENY
SEIFERT, MD, THOMAS E	CAMBRIA
SEIFERTH, MD, WILLIAM J	ERIE
SEIGLE, MD, WALTER E	LACKAWANNA
SEIN, MD, PHYU P	PHILADELPHIA
SEINIGE, MD, URSULA L	PHILADELPHIA
SEIPLE, MD, HARVEY H	LANCASTER
SEITCHIK, MD, MURRAY W	PHILADELPHIA
SEITCHIK, MD, SCOTT H	PHILADELPHIA
SEITMAN, MD, DAVID T	BUCKS
SEITZ, MD, EDWARD R	ALLEGHENY
SEITZ, MD, NEVIN H	YORK
SEITZ JR, MD, HORACE M	PHILADELPHIA
SEKARAN, MD, KAMALESH K	BUTLER
SEKARAN, MD, SOMASUNDARAM K	BUTLER
SEKERES, MIKKAEL A	STUDENT
SEKULA-PERLMAN, MD, ADRIENNE	PHILADELPHIA
SELBST, MD, STEVEN M	PHILADELPHIA
SELBY, MD, CHARLES L	MONTGOMERY
SELBY, RACHEL M	STUDENT
SELCER, MD, UZI M	PHILADELPHIA
SELICKMAN, MD, MITCHELL A	PHILADELPHIA
SELIG, MD, MICHAEL B	NORTHAMPTON
SELIG, MD, ROBERT M	PHILADELPHIA
SELINGO, MD, JAMIE A	PHILADELPHIA
SELKER, MD, ROBERT G	ALLEGHENY
SELKOVITS, MD, SIDNEY	ALLEGHENY
SELL, MD, HARRY W	ALLEGHENY
SELLARO, DO, SALVATORE R	ERIE
SELLERS, MD, ALFRED M	PHILADELPHIA
SELTZER, MD, HARRY	ALLEGHENY
SELTZER, MD, JOSEPH L	PHILADELPHIA
SELVAGGI, MD, KATHY J	ARMSTRONG
SELVAGGIO, MD, ADRIANA M	ALLEGHENY
SELVARAJ, MD, MYLAPPAN	BUTLER
SELVARAJ, MD, VIJAYALAKSHMI	BUTLER
SELVARAYAN, MD, PHILIP T	LUZERNE
SEMANOFF, MD, THEOPHILA C	BUCKS
SEMBROT, MD, WILLIAM B	PHILADELPHIA
SEMINS, MD, HOWARD	ALLEGHENY
SEMPLE, DO, JAMES F	ALLEGHENY
SEMPLE, MD, JOSEPH M	ERIE
SEMPOWSKI, DO, TIMOTHY J	PHILADELPHIA
SENAN, MD, PUSHPENDRA	ALLEGHENY
SENECAL, MD, KEITH E	FRANKLIN
SENFT, MD, KAREN E	NORTHAMPTON
SENFT, MD, STEPHEN C	NORTHAMPTON
SENGSTAKEN, MD, ELIZABETH A	PHILADELPHIA
SENITA, MD, G ROBERT	ALLEGHENY
SENTER, MD, HOWARD J	ALLEGHENY
SEO, MD, JIN S	BERKS
SEPESKY, MD, VICTORIA M	STUDENT
SERAFY, MD, MICHAEL M	ALLEGHENY
SERBER, MD, WILLIAM	PHILADELPHIA
SERENA, MD, THOMAS E	WARREN
SERENE, MD, HARRY E	ALLEGHENY
SERFAS, MD, LEE S	NORTHAMPTON
SERGI, MD, MICHAEL A	BERKS
SERGI, MD, TIFFANY L	BERKS
SERGOTT, MD, ROBERT C	PHILADELPHIA
SEROTA, DO, BENJAMIN	PHILADELPHIA
SERPICO, DO, PETER C	BUCKS
SERRANO, MD, ALBERTO C	PHILADELPHIA
SERRIAN JR, MD, JOHN L	PHILADELPHIA
SERWINT, MD, MICHAEL S	LYCOMING
SESHADRI, MD, VIJAYA G	INDIANA
SESKI, MD, JAN C	ALLEGHENY
SESOK PIZZINI, DEBORAH A	STUDENT
SESSOMS, MD, FRANK E	ALLEGHENY
SETH, MD, PRABHAT	ALLEGHENY
SETH, MD, RAJENDRA N	PHILADELPHIA
SETHI, MD, PRADEEP K	ALLEGHENY
SETHI, MD, SURENDRA K	BUTLER
SETLOCK, DO, WALTER W	SCHUYLKILL
SETO, DO, PATRICIA	DAUPHIN
SETTY, MD, POLEPALLI S	WESTMORELAND
SETZENFAND, MD, ROY A	STUDENT
SEVCIK, MD, MATTHEW F A	ALLEGHENY
SEVICK, MD, MYRON E	CENTRE
SEWAK, MD, MICHAEL E	CAMBRIA
SEWARDS, MD, PATRICK M	LEHIGH
SEWATSKY, MD, MARY F	LACKAWANNA
SEXTON JR, MD, GEORGE L	BERKS
SEY, MD, MARK J	PHILADELPHIA
SEYEDZADEH, MICHELLE	STUDENT
SEYLER, MD, RAYMOND Q	DELAWARE
SGARLAT, MD, JOSEPH R	LUZERNE
SGRO, MD, ANTONIO	PHILADELPHIA
SHABLIN, BRIAN K	STUDENT
SHABLOSKI, DO, REGAN P	ERIE
SHACKLETT, MD, DOROTHY E	PHILADELPHIA
SHAD, MD, AZIZA T	DAUPHIN
SHADDUCK, MD, RICHARD K	ALLEGHENY
SHADDUCK, MD, SNEED P	BERKS
SHADLE, MD, CHESTER A	YORK
SHAEFFER, MD, JOSEPH M	BUCKS
SHAFER, MD, EDWARD A	LUZERNE
SHAFFER, MD, CAROLYN W	DAUPHIN
SHAFFER, MD, EUGENE M	BERKS
SHAFFER, MD, GEORGE W	BUCKS
SHAFFER, MD, HOWARD L	LAWRENCE
SHAFFER, MD, IRVIN G	BERKS
SHAFFER, MD, LAWRENCE A	MERCER
SHAFFER, DO, LINDA E	DELAWARE
SHAFFER, MD, LIONEL B	MONTGOMERY
SHAFFER, DO, TANA M	NORTHMBRLAND
SHAFFER, MD, TERRY D	LAWRENCE
SHAFFER, MD, WALTER L	ALLEGHENY
SHAFIA, MD, HASS	PHILADELPHIA
SHAFIQUE, MD, MOHAMMAD	LYCOMING
SHAH, MD, AJIT N	ALLEGHENY
SHAH, AMIT R	STUDENT
SHAH, MD, ANILKUMAR T	LUZERNE
SHAH, ASHISH S	STUDENT
SHAH, ASIT K	STUDENT
SHAH, MD, EVELYN M	LUZERNE
SHAH, MD, GHAZANFAR A	JEFFERSON
SHAH, MD, GIRISH J	MONTGOMERY
SHAH, MD, HARNISH V	BERKS
SHAH, HIREN M	STUDENT
SHAH, MD, JITENDRA N	PHILADELPHIA
SHAH, MD, MAHENDRA C	PHILADELPHIA
SHAH, MD, MAHENDRA K	SUSQUEHANNA
SHAH, MD, MANJULA S	JEFFERSON
SHAH, MD, MEHUL N	MONTGOMERY
SHAH, MD, MUKTA K	MIFFLIN/JUNIATA
SHAH, MD, NARAYAN	MONTOUR
SHAH, MD, NAYAN C	LACKAWANNA
SHAH, MD, RAHMAT	LACKAWANNA
SHAH, MD, RANJAN R	DELAWARE
SHAH, MD, RANJIT R	DELAWARE
SHAH, MD, RATAN S	WESTMORELAND
SHAH, MD, SAMIRKUMAR J	ALLEGHENY
SHAH, MD, SATISH A	ADAMS
SHAH, MD, SHAILEN R	PHILADELPHIA
SHAH, MD, SHIRISH N	ALLEGHENY
SHAH, MD, SUSIE S	PHILADELPHIA
SHAH, MD, SYED G	SCHUYLKILL
SHAH, MD, VINOD H	ALLEGHENY
SHAHID, MD, MIAN M A	CARBON
SHAIKH, MD, AYESHA R	LACKAWANNA
SHAIKH, MD, KHALEEL A	LACKAWANNA
SHAIKH, MD, M NASIR	WESTMORELAND
SHAIKH, MD, SAEED R	DAUPHIN
SHAKIN, MD, ERIC P	DELAWARE
SHALLEY, MD, ANN M	ALLEGHENY
SHAMPAIN, MD, MARK P	LEHIGH
SHANAGHAN, DO, KEVIN J	LYCOMING
SHANAHAN, MD, J RUSH	PHILADELPHIA
SHANAHAN, MD, NANCY R	BUCKS
SHANER, MD, CATHARINE L	LEHIGH
SHANER, DO, THOMAS N	LYCOMING
SHANFELD, MD, NORMAN M	DELAWARE
SHANGOLD, MD, MONA M	PHILADELPHIA
SHANK, MD, IRENE A	ALLEGHENY
SHANK, MD, PAUL W	SOMERSET
SHANMUGAM, MD, KASINATHAN	WARREN
SHAPIRA, MD, EDITH L	ALLEGHENY
SHAPIRO, MD, AARON L	PHILADELPHIA
SHAPIRO, MD, ALVIN P	ALLEGHENY
SHAPIRO, MD, BARBARA S	PHILADELPHIA
SHAPIRO, MD, BENNETT M	BUCKS
SHAPIRO, MD, BERNARD	PHILADELPHIA
SHAPIRO, MD, BRYAN E	CAMBRIA
SHAPIRO, MD, CHARLES J	FRANKLIN
SHAPIRO, DO, ERIC B	DELAWARE
SHAPIRO, MD, ERIC D	LEHIGH
SHAPIRO, MD, JOHN A	BERKS
SHAPIRO, MD, LEONARD H	PHILADELPHIA
SHAPIRO, MD, LESTER F	ALLEGHENY
SHAPIRO, MD, MORRY	ALLEGHENY
SHAPIRO, MD, STEVEN L	YORK
SHAPIRO, MD, TIMOTHY A	MONTGOMERY
SHAPREN, KRISTEN M	STUDENT
SHARBAUGH, MD, DONALD G	BEDFORD
SHARE, MD, FREDERICK S	PHILADELPHIA
SHARE, LISA J	STUDENT
SHARIFF, MD, HAJI M	PHILADELPHIA
SHARIFF, MD, YASMEEN K	ALLEGHENY
SHARIFI-AZAD, MD, SAID	PHILADELPHIA
SHARKEY, MD, THOMAS G	LUZERNE
SHARKEY JR, MD, SEAN J	LANCASTER
SHARMA, MD, AMAR J	NORTHAMPTON
SHARMA, MD, BRAHMA N	ALLEGHENY
SHARMA, MD, MEERA V	LACKAWANNA
SHARMA, MD, OM P	NORTHAMPTON
SHARMA, MD, PARMINDER K	ALLEGHENY
SHARMA, MD, RANJANA S	CUMBERLAND
SHARMA, MD, ROHIT	ALLEGHENY
SHARMA, MD, SUKH D	ERIE
SHARP JR, MD, JOHN W	LANCASTER
SHARPLESS, MD, EDWIN D	DELAWARE
SHARPNACK, MD, BRUCE C	WASHINGTON
SHARPS, MD, FRANK	PHILADELPHIA
SHARRER, MD, MARGARET C	ALLEGHENY
SHATTEN, MD, THOMAS A	ALLEGHENY
SHATZ, MD, RICHARD N	LYCOMING
SHAUB JR, MD, HOWARD G	BLAIR
SHAUGHNESSY, MD, MICHAEL J	ALLEGHENY
SHAULL, MD, MELISSA A	YORK
SHAVER, MD, ELLEN G	PHILADELPHIA
SHAVER, MD, JAMES A	ALLEGHENY
SHAVER, MD, JOHN C	ALLEGHENY
SHAVER, MD, ROBERT D	LEBANON
SHAW, MD, CAROLYN C	PHILADELPHIA
SHAW, DAVID J	STUDENT
SHAW, MD, DIANA S	NORTHAMPTON
SHAW, DO, DONALD D	TIOGA
SHAW, MD, ELLEN M	MONTGOMERY
SHAW, MD, GORDON A	LYCOMING
SHAW, MD, JAMES A	DAUPHIN
SHAW, JENNIFER A	STUDENT
SHAW, MD, KATHY N	PHILADELPHIA
SHAW, MD, WILLIAM I	ALLEGHENY
SHAW III, MD, LEWIS C	DAUPHIN
SHAWALUK, MD, PAUL D	PHILADELPHIA
SHAWI, MD, JOSEPH I	BUTLER
SHAY, MD, PAUL L	ALLEGHENY
SHEAFFER, MD, HAROLD C	DELAWARE
SHEARBURN III, MD, EDWIN W	BUCKS
SHEARER, MD, DAVID M	YORK
SHEARER, MD, DONALD E	LYCOMING
SHECHTER, MD, JAY A	LACKAWANNA
SHECTER, DO, FREDRIC M	PHILADELPHIA
SHEDDEN, MD, ARTHUR H	MONTGOMERY
SHEDRO, MD, HECTOR	WESTMORELAND
SHEEDY, MD, JOHN G	BLAIR
SHEEHE, MD, DENNIS M	COLUMBIA
SHEELY, MD, RAYMOND F	ADAMS
SHEER, MD, GEORGE W	LACKAWANNA
SHEETS, MD, EVERETT O	PHILADELPHIA
SHEETS, MD, JAMES A	LEHIGH
SHEETS, KIMBERLY R	STUDENT
SHEFFER, MD, M LEONARD	BERKS
SHEFFIELD, MD, JOHN C	ALLEGHENY
SHEFFO, MD, GREGORY S	ALLEGHENY
SHEIKH, MD, AZHAR S	ALLEGHENY
SHEIKH, EMRAN S	STUDENT
SHEINBAUM, MD, ROY J	PHILADELPHIA
SHELANSKI, MD, SHARON L	PHILADELPHIA
SHELDON, MD, DOUGLAS L	LACKAWANNA
SHELLEY, MD, LISBETH E	ALLEGHENY
SHELLEY, MD, MARK H	MCKEAN
SHELLEY, MD, WILLIAM L	CUMBERLAND
SHELLING, MD, RICHARD E	BRADFORD
SHELLY, MD, ROBERT M	SUSQUEHANNA
SHELTON, MD, BARBARA	PHILADELPHIA
SHEMANSKI, MD, CLEM J	BERKS
SHEMER, DO, RANDY R	BEAVER
SHEN, R ROY	STUDENT
SHENAI, MD, PUNDALIK G	DAUPHIN
SHENBERGER, MD, KEITH N	LYCOMING
SHENKIN, MD, HENRY A	PHILADELPHIA
SHEPARD, MD, WILLIAM R	MONTGOMERY
SHEPHERD, MD, LORI L	YORK
SHEPPARD, MD, EDITH S	MONTGOMERY
SHEPPARD, MD, SCOTT F	ALLEGHENY
SHEPPARD, DO, STEVEN R	YORK
SHEPPECK, MD, RICHARD A	WESTMORELAND
SHEPPS, CRAIG D	STUDENT
SHEPTAK, MD, PETER E	ALLEGHENY
SHER, MD, LIANE	PHILADELPHIA
SHER, MD, PAUL B	PHILADELPHIA
SHER, PETER M	STUDENT
SHER, MD, SCOTT A	PHILADELPHIA
SHERBAN, MD, PAUL R	LANCASTER
SHERBOTIE, MD, JOSEPH R	PHILADELPHIA
SHERK, MARY H	STUDENT
SHERMAN, MD, ALFRED J	DAUPHIN
SHERMAN, MD, ANTHONY	PHILADELPHIA
SHERMAN, CAROLYN E	STUDENT
SHERMAN, MD, HENRY K	ALLEGHENY
SHERMAN, MD, M JACKSON	PHILADELPHIA
SHERMAN, MD, SAMUEL	ALLEGHENY
SHERRY, MD, MICHAEL M	ALLEGHENY
SHERTZER, MD, JOHN H	LANCASTER
SHERWIN, MD, EDWARD A	LACKAWANNA
SHERWIN, MD, NANCY M	DELAWARE
SHERWIN, MD, ROBERTA	PHILADELPHIA
SHERWIN, MD, WILLIAM K	MONTGOMERY
SHERWOOD, MD, ARTHUR W	WYOMING
SHERWOOD, MD, JOHN W	LUZERNE
SHETE, MD, LEENA P	WESTMORELAND
SHETH, MD, MALAY C	WASHINGTON
SHETH, MD, VIRAL R	PHILADELPHIA
SHETTER, MD, THOMAS G	BUTLER
SHETTY, MD, ASHOK K	WESTMORELAND
SHETTY, MD, BALU B	ALLEGHENY
SHETTY, MD, K NARAYAN	BEAVER
SHETTY, MD, KARUNAKAR S	WESTMORELAND
SHETTY, MD, MANOHAR	ALLEGHENY
SHETTY, MD, NANDALIKE S	MERCER
SHETTY, MD, RATNAKAR S	BEAVER
SHETTY, MD, SARVOTHAM N	BEAVER
SHETZLEY, MD, CARL M	BUCKS
SHEVCHIK, MD, GRANT J	WESTMORELAND
SHIAU, MD, YIH-FU	DELAWARE
SHIBUTANI, MD, YASUSHI F	MONTGOMERY
SHIEH, JOSEPH T C	STUDENT
SHIEH, MD, KAN C	LEHIGH
SHIELDS, MD, JERRY A	PHILADELPHIA
SHIELDS, MD, JOHN J	MONTGOMERY
SHIELDS, MD, MARY S	LEHIGH
SHIELDS, MD, PHILIP T	ALLEGHENY
SHIELDS, MD, RALPH L	NORTHAMPTON
SHIELDS, MD, THOMAS J	MONTGOMERY
SHIENBAUM, ALAN J	STUDENT
SHIH, HENRY T	STUDENT
SHILLING, MD, JACK W	STUDENT
SHILOH, AARON O	STUDENT
SHIM, MD, CHUNGJA C	VENANGO
SHIM, MD, WAN S	DELAWARE
SHIMER, RICHARD T	STUDENT
SHIN, BRIAN J	STUDENT
SHIN, EDWARD J	STUDENT
SHIN, MD, HEE JOON	NORTHAMPTON
SHIN, MD, MAUNG T	ERIE
SHIN, MD, MICHAEL M	DELAWARE
SHIN, SOON K	STUDENT
SHINDEL, MD, JAMES H	BLAIR
SHINDLER, MD, ROBERT L	DAUPHIN
SHINGALA, MD, ARUN J	LACKAWANNA
SHINN, MD, SARAH B	ALLEGHENY
SHINNICK, DO, JAMES P	PHILADELPHIA
SHIPKOVITZ, MD, HARVEY D	ALLEGHENY
SHIPPEN, MD, EUGENE R	BERKS
SHIPTON, DO, WILLIAM E	SCHUYLKILL
SHIREY, MD, ELAINE D	CHESTER
SHISHAK, MD, ARYO A	WAYNE/PIKE
SHIVDE, MD, PINAKINI	ERIE
SHMOKLER, MD, MITCHELL F	DELAWARE
SHOCKMAN, MD, JOEL	PHILADELPHIA
SHOEMAKER, MD, DAVID M	BUCKS
SHOEMAKER, MD, ELLIOT I	LEHIGH
SHOEMAKER, MD, LARRY D	PHILADELPHIA
SHOEMAKER, MD, MARGRIT M	LYCOMING
SHOEMAKER, MD, PATRICIA L	LEHIGH
SHOEMAKER, DO, STEPHEN N	LUZERNE
SHOENBERGER, MD, DOUGLAS C	LEHIGH
SHOENER, MD, JOHN A	ALLEGHENY
SHOENTHAL, MD, DONALD R	ALLEGHENY
SHOENTHAL, MD, WILLIAM J	BUCKS
SHOGAN, MD, JEFFREY E	ALLEGHENY
SHOGRY, MD, ROBERT N	ALLEGHENY
SHOLDER, MD, ARNOLD J	ALLEGHENY
SHOLEHVAR, MD, JAVAD	LEHIGH
SHOLEVAR, MD, FARHAD	LEHIGH
SHONBERG, MD, BARBARA H	BUCKS
SHONBERG, MD, IRVING L	ALLEGHENY
SHONNARD, MD, JOHN W	VENANGO
SHOOK, III,, MD, WILLIS D	ALLEGHENY
SHOPE, MD, EARL S	BEDFORD
SHOPE, TIMOTHY R	STUDENT
SHORE, MD, PAUL D	DELAWARE
SHORE, PAUL M	STUDENT
SHORE, MD, ROBERT A	MONTGOMERY
SHORE, MD, ROGER J	CLARION
SHORE, MD, SEYMOUR M	PHILADELPHIA
SHORE, MD, SIDNEY	MONTGOMERY
SHORE, MD, STEPHEN A	DELAWARE
SHORT, MD, JOHN G	PHILADELPHIA
SHOURAIE, MD, ZARRIN	PHILADELPHIA
SHOVLIN, MD, J MICHAEL	LACKAWANNA
SHOWERS, DO, THOMAS L	LANCASTER
SHRAGER, DO, LARRY M	DELAWARE
SHRAGER, MD, MORTON W	PHILADELPHIA
SHREINER, MD, DAVID P	ALLEGHENY
SHRIKANTHAN, MD, SANKARAN	ALLEGHENY
SHRIVASTAVA, RAJ K	STUDENT
SHROFF, MD, FAROOK K	LUZERNE
SHROM, MD, STANLEY H	DELAWARE
SHU, MD, JASON C	LYCOMING
SHU, JOHN W	STUDENT
SHUBIN, MD, HARRY	PHILADELPHIA
SHUE, MD, WILLIAM M	YORK
SHUGERT, MD, GUY S	BEAVER
SHUGERT, MD, JOHN H	BEAVER
SHUKLA, MD, ROHITKUMAR S	FRANKLIN
SHULKIN, MD, DAVID J	PHILADELPHIA
SHULKIN, MD, MARK W	DELAWARE
SHULMAN, MD, JOHN F	PHILADELPHIA
SHULTZ, MD, BARRY S	BERKS
SHULTZ, MD, ROBERT G	LANCASTER
SHULTZ, MD, THOMAS L	BUCKS

SHUMAN, MD, CHARLES R	PHILADELPHIA
SHUMAN, MD, JOHN F	BERKS
SHUMAN, MD, LEIGH S	LANCASTER
SHUMAN, MD, NANCY A	BERKS
SHUMAN, MD, SANDRA J	PHILADELPHIA
SHUNG-LU, MD, TA	BRADFORD
SHURMAN, BRETT D	STUDENT
SHUSMAN, MD, ROBERT S	DELAWARE
SHUSTER, MD, EUGENE	PHILADELPHIA
SHUSTERMAN, DO, LARRY	DELAWARE
SHUSTERMAN, MD, NEIL H	PHILADELPHIA
SHUSTERMAN, MD, RICHARD D	BUCKS
SHUTACK, DO, JOHN G	PHILADELPHIA
SHUTACK, JOHN M	STUDENT
SHUTTER, MD, WALTER D	WESTMORELAND
SHUTTLEWORTH, MD, LAMONT V	ALLEGHENY
SHYAMALAN, MD, JAYALAKSHMI	PHILADELPHIA
SHYAMALAN, MD, NELLIATE C	PHILADELPHIA
SHYMANSKY, MD, J STEPHEN	ALLEGHENY
SHYMANSKY, MD, LAURA M	ALLEGHENY
SHYNN, MD, TAE I	LUZERNE
SIA, MD, JOSE K	BEAVER
SIAM, MD, NABIL A	PHILADELPHIA
SIAR, MD, W JOHN	JEFFERSON
SIBINGA, MD, MAARTEN S	DELAWARE
SIBLEY, MD, ROBERT E	LACKAWANNA
SIBOLBORO, MD, ISABELO Z	INDIANA
SICHER, MD, BRUNO P	MCKEAN
SICKEL, MD, EDWARD F	DAUPHIN
SICKORA, DO, MARK S	ALLEGHENY
SICONOLFI, MD, ERNEST P	ALLEGHENY
SICURANZA, MD, MICHAEL J	YORK
SIDARI, MD, JUDE F	LUZERNE
SIDDIQI, MD, TARIQ	PHILADELPHIA
SIDDIQUI, MD, SHEHLA S	MONTGOMERY
SIDDOWAY, MD, LYLE A	YORK
SIDHU, MD, PREETIKA K	DAUPHIN
SIDOROV, MD, JAAN E	MONTOUR
SIEBER, MD, PAUL R	LANCASTER
SIEBER, MD, WILLIAM K	ALLEGHENY
SIEGAL, MD, TODD L	PHILADELPHIA
SIEGEL, MD, AYN D	UNION
SIEGEL, MD, BERNARD	PHILADELPHIA
SIEGEL, MD, JOSEPH F	WASHINGTON
SIEGEL, MD, PAUL D	PHILADELPHIA
SIEGEL, MD, SEYMOUR	PHILADELPHIA
SIEGEL, MD, WILLIAM	BUCKS
SIEGELBAUM, MD, STEVEN P	DAUPHIN
SIEGER, MD, DAVID D	LANCASTER
SIEGFRIED, MD, JAY W	PHILADELPHIA
SIEGFRIED, MD, MYRTLE M	LEHIGH
SIEGLER, MD, PETER E	PHILADELPHIA
SIEGRIST, MD, J DONALD	LANCASTER
SIEMS, LAURA J	STUDENT
SIEPER, DO, WILLIAM J	WESTMORELAND
SIEPSER, MD, STEVEN B	CHESTER
SIERZENSKI, RONALD J	STUDENT
SIESHOLTZ, MD, THOMAS S	BUCKS
SIEWERS, MD, CHRISTIANE	ALLEGHENY
SIEWERS, MD, RALPH D	ALLEGHENY
SIFFRING, MD, CORYDON W	YORK
SIGAFOOS, EXEC SEC, SALLY J	LANCASTER
SIGAL, MD, MICHAEL B	ALLEGHENY
SIGLER, MD, MILES H	PHILADELPHIA
SIGMUND, MD, WILLIAM J	LANCASTER
SIGNORELLA, MD, ARTHUR P	ALLEGHENY
SIGNORELLA, MD, LOUIS	WASHINGTON
SIGUENZA, MD, ROBERT F	DAUPHIN
SIHA, MD, VICTOR L	ALLEGHENY
SIKER, MD, EPHRAIM S	ALLEGHENY
SIKORSKI, MD, CYNTHIA S	STUDENT
SILBER, MD, JEFFREY H	PHILADELPHIA
SILBERMAN, MD, DAVID A	BUCKS
SILBERMAN, MD, IRA	PHILADELPHIA
SILBERMAN, MD, LESLIE J	ALLEGHENY
SILBERMAN, MD, ROBERT M	NORTHAMPTON
SILBERSTEIN, MD, MARSHA M	PHILADELPHIA
SILBERSTEIN, MD, STEPHEN D	PHILADELPHIA
SILBERZWEIG, MD, JEFFREY I	PHILADELPHIA
SILENZIO, MD, VINCENT M B	PHILADELPHIA
SILER, MD, JANET N	PHILADELPHIA
SILIQUINI, MD, JOHN J	PHILADELPHIA
SILK, MD, RAYMOND E	PHILADELPHIA
SILLARS, MD, CHARLES H	MONTGOMERY
SILOS, STEPHANIE A	STUDENT
SILVA-LOPEZ, MD, EDIBALDO	MONTOUR
SILVAGGIO, MD, TERESA	ALLEGHENY
SILVER, MD, BARRY A	MONTGOMERY
SILVER, MD, BERNICE S	PHILADELPHIA
SILVER, MD, BRUCE G	DELAWARE
SILVER, MD, FRANK	PHILADELPHIA
SILVER, MD, ISRAEL O	DAUPHIN
SILVER, MD, LAURENCE M	MONTGOMERY
SILVER, MD, LAWRENCE B	DAUPHIN
SILVER, MD, LYNNE J	PHILADELPHIA
SILVER, DO, MARC R	PHILADELPHIA
SILVER, MD, RICHARD C	DELAWARE
SILVER, MD, SAUL J	ALLEGHENY
SILVER, MD, SCOTT J	YORK
SILVER, MD, STEPHEN C	DELAWARE
SILVERBERG, MD, ALAN	CHESTER
SILVERBERG, MD, ALAN L	BUCKS
SILVERBERG, MD, BRUCE J	LEHIGH
SILVERBERG, MD, DANIEL M	LEHIGH
SILVERBERG, MD, JAY H	ALLEGHENY
SILVERBLATT, MD, BERNARD L	ALLEGHENY
SILVERBLATT, MD, MARVIN L	ALLEGHENY
SILVERIO, MD, JOHN	CHESTER
SILVERMAN, MD, ALAN R	ALLEGHENY
SILVERMAN, MD, ALEXANDER	ALLEGHENY
SILVERMAN, MD, EDWARD J	BERKS
SILVERMAN, DO, EDWARD M	PHILADELPHIA
SILVERMAN, MD, HOWARD A	LEHIGH
SILVERMAN, MD, JERRY D	ALLEGHENY
SILVERMAN, MD, JOSEPH S	BLAIR
SILVERMAN, MD, MENDEL	ALLEGHENY
SILVERMAN, MD, MORTON I	LEHIGH
SILVERMAN, MD, MORTON L	MONTGOMERY
SILVERMAN, MD, STUART L	ALLEGHENY
SILVERMAN, MD, WILLIAM H	NORTHAMPTON
SILVERMAN, MD, WILLIAM S	PHILADELPHIA
SILVERS, MD, ABIGAIL A	MONTGOMERY
SILVERS, MD, ARTHUR H	DELAWARE
SILVERSTEIN, MD, ALAN J	ALLEGHENY
SILVERSTEIN, MD, CHARLES E	ALLEGHENY
SILVERSTEIN, MD, DANIEL K	LUZERNE
SILVERSTEIN, MD, GARY S	PHILADELPHIA
SILVERSTEIN, MD, LEONARD I	MONTGOMERY
SILVERSTEIN, DO, SCOTT D	LANCASTER
SILVERSTEIN, SCOTT L	STUDENT
SILVERSTINE, MD, LESLIE B	MCKEAN
SILVERTON, MD, SUSAN F	MONTGOMERY
SILVIS, MD, HARRY J	WASHINGTON
SIM, MD, HYUN S	ARMSTRONG
SIMAN, MD, BERNARD	PHILADELPHIA
SIMERMAN, MD, LEE PAUL	PHILADELPHIA
SIMKINS, MD, JO M	ALLEGHENY
SIMMONDS, MD, MARY A	DAUPHIN
SIMMONS, MD, CHESTON	CHESTER
SIMMONS, MARK L	STUDENT
SIMMONS, MD, RICHARD L	ALLEGHENY
SIMON, MD, DAVID L	LYCOMING
SIMON, JEFFREY A	STUDENT
SIMON, MD, KATHRYN K	MONTGOMERY
SIMON, MD, WILLIAM H	PHILADELPHIA
SIMONE, MD, FRANK J	INDIANA
SIMONE, MD, SAMUEL T	ALLEGHENY
SIMONIAN, MD, THOMAS M	ERIE
SIMONS, MD, CARL I	BUCKS
SIMONS, MD, LAWRENCE M	BEDFORD
SIMONS, MD, RICHARD J	DAUPHIN
SIMONS, MD, ROBERT M	MONTGOMERY
SIMONS, MD, WILLIAM M	MONROE
SIMONSEN, MD, RONALD W	WARREN
SIMORA, MD, FELIX S	ERIE
SIMPSON, MD, JOSEPH W	PHILADELPHIA
SIMPSON, MD, ROY W	LACKAWANNA
SIMPSON, ZACHARY W	STUDENT
SIMS, MD, CYNTHIA J	ALLEGHENY
SINAIKO, MD, PETER A	BUCKS
SINCAVAGE, MD, JOSEPH T	DELAWARE
SINCLAIR, MD, CATHERINE P	WASHINGTON
SINCLAIR, MD, MICHAEL C	LEHIGH
SINCLAIR, MD, STEPHEN H	PHILADELPHIA
SINE-KARASICK, DO, MADELYN	MONTGOMERY
SING, DO, RONALD F	PHILADELPHIA
SINGAL, MD, BRENDA B	YORK
SINGAL, MD, RAJESH	YORK
SINGER, DANIEL A	STUDENT
SINGER, MD, EDWARD S	PHILADELPHIA
SINGER, MD, FRED	PHILADELPHIA
SINGER, MD, IRVIN	PHILADELPHIA
SINGER, MD, JEROME	DELAWARE
SINGER, MD, JOSEPH D	MONTGOMERY
SINGER, MD, RAYMOND L	LEHIGH
SINGER, MD, WILLIAM H	LEHIGH
SINGH, MD, AJAY P	SOMERSET
SINGH, MD, AMARJEET R	BEAVER
SINGH, MD, ANJALI H	PHILADELPHIA
SINGH, MD, ARVIND K	LACKAWANNA
SINGH, MD, ASIM R	ERIE
SINGH, MD, BHUPINDER P	CUMBERLAND
SINGH, MD, BIJAI B	INDIANA
SINGH, MD, BINOY K	PHILADELPHIA
SINGH, MD, DALJIT	ALLEGHENY
SINGH, MD, GURCHARAN	PHILADELPHIA
SINGH, MD, GURDIAL N	NORTHUMBRLAND
SINGH, MD, GURMIT	ALLEGHENY
SINGH, MD, GURSHARAN	SCHUYLKILL
SINGH, MD, MALKIT	FAYETTE
SINGH, MD, RAJENDRA	SCHUYLKILL
SINGH, MD, SONIA	ALLEGHENY
SINGH, MD, SUNANDA	PHILADELPHIA
SINGH, MD, SURENDER	LANCASTER
SINGH, MD, VIJAI P	FAYETTE
SINGHI, MD, SUSHIL K	ALLEGHENY
SINGLETON, MARLYNN	STUDENT
SINGLEY, MD, THOMAS L	FAYETTE
SINGSON, MD, PETER P	PHILADELPHIA
SINHA, MD, LINA M	PHILADELPHIA
SINHA, MD, RAJ KAMAL	PHILADELPHIA
SINK, MD, JAMES D	PHILADELPHIA
SINKER, MD, DALE V	PHILADELPHIA
SINNOTT, DO, ROBERT J	BUCKS
SINOR, MD, BAKHTI	ALLEGHENY
SINZ, MD, ELIZABETH H	ALLEGHENY
SIPE, KELLY L	STUDENT
SIPE, MD, PAUL G	YORK
SIPES, MD, DUANE E	FRANKLIN
SIPES, MD, EARL K	LEHIGH
SIRIO, MD, CARL A	ALLEGHENY
SIRIPONG, MD, SILPACHAI	LAWRENCE
SIRKEN, DO, DAVID H	PHILADELPHIA
SIROTNAK JR, MD, JOHN J	LACKAWANNA
SIROTTA, MD, PAUL S	LEHIGH
SISSON, MD, RALPH S	NORTHAMPTON
SITKOFF, DO, ANDREW D	CHESTER
SIVALINGAM, MD, ARUNAN	PHILADELPHIA
SIVALINGAM, MD, JOCELYN F	PHILADELPHIA
SIVENDRAN, MD, THARMALINGAM	ADAMS
SIVICK JR, MD, DONALD A	MONTGOMERY
SIVITZ, MD, MARTA E	PHILADELPHIA
SIVITZ, MD, MICHAEL C	MONTGOMERY
SIVULICH, MD, MICHAEL J	CAMBRIA
SIWEK, YVONNE E	STUDENT
SIXBEY, THOMAS R	STUDENT
SJOVALL, DO, FRANCES	LEBANON
SKALINA, MD, STEFAN M	DELAWARE
SKEEHAN, MD, THOMAS M	DAUPHIN
SKEEN, MD, JAMES T	DAUPHIN
SKELLY, MD, WILLIAM J	LYCOMING
SKERL, MD, ANTON O	BLAIR
SKERRETT, MD, PHILIP V	PHILADELPHIA
SKETTINO, MD, JOSEPH A	LACKAWANNA
SKIENDZIELEWSKI, MD, JOHN J	MONTOUR
SKINNER, MD, DOUGLAS V	ALLEGHENY
SKINNER III, MD, ROBERT W	LANCASTER
SKLAROFF, MD, DAVID M	PHILADELPHIA
SKLAROFF, MD, ROBERT B	PHILADELPHIA
SKLAVENITOU, MD, VASSILIKI	PHILADELPHIA
SKLIZOVIC, MD, DAVOR G	ALLEGHENY
SKOBIERANDA, MD, KATHE R	DAUPHIN
SKOLNICK, MD, BRUCE A	PHILADELPHIA
SKOLNICK, MD, KENNETH B	BEAVER
SKONIECZKI III, MD, STAN R	YORK
SKORINKO, MD, KENNETH P	NORTHAMPTON
SKORPINSKI, MD, EDWARD W	BERKS
SKOTNICKI, DO, ROBERT A	DAUPHIN
SKOVIRA, MD, EDWARD M	LACKAWANNA
SKOVRON, MD, MICHAEL	ERIE
SKOWRONSKI, MD, THEODORE J	MONTGOMERY
SKRENTA, MD, RICHARD J	ALLEGHENY
SKRENTNY, MD, THOMAS T	BLAIR
SKROMAK, MD, STANLEY J	PHILADELPHIA
SKURA, MD, DOUGLAS S	ALLEGHENY
SKUTCHES, MD, JOSEPH M	NORTHAMPTON
SKVERSKY, MD, NORMAN J	PHILADELPHIA
SKWEIR, MD, LEON A	LEHIGH
SKWIRUT, MD, FRANK A	DELAWARE
SLABIC, MD, PETER P	ERIE
SLABIC, MD, STAN F	ERIE
SLADE, MD, ROBERT N	NORTHAMPTON
SLADKY, MD, JOHN T	PHILADELPHIA
SLAGLE, MD, EDWARD H	ALLEGHENY
SLANDZICKI, MD, ALEX J	ERIE
SLANINA, MD, MICHAEL S	PHILADELPHIA
SLAP, MD, JOSEPH W	PHILADELPHIA
SLATALLA, MATT D	STUDENT
SLATER, MD, HARVEY	ALLEGHENY
SLATER, MD, KENNETH C	CARBON
SLATER, MD, ROBERT	DELAWARE
SLAVIN, MD, DOROTHY A	PHILADELPHIA
SLAVIN, MD, JAMES W	PHILADELPHIA
SLAVISH, MD, LYDIA G	BERKS
SLAVOSKI, MD, LINDA A	DELAWARE
SLAYTON, MD, ROBERT I	ALLEGHENY
SLEDZ, MD, ANN MARIE	NORTHAMPTON
SLEMENDA, MD, WILLIAM D	BEAVER
SLENKER, MD, KEVIN F	LANCASTER
SLEPECKI, MD, EVA M	MONTOUR
SLEZAK, MD, JOSEPH A	WESTMORELAND
SLICK, MD, GREGORY	BEDFORD
SLIMMER JR, MD, SAMUEL C	SCHUYLKILL
SLIMOVITCH, MD, CAROLINE L	ALLEGHENY
SLIWINSKI, MD, STANLEY J	BUCKS
SLOAN, MD, CHARLES R	FAYETTE
SLOAN, MD, RICHARD W	YORK
SLOANE, MD, BRUCE B	PHILADELPHIA
SLOANE, MD, CHARLES E	WESTMORELAND
SLOCHOWER, MD, DENNIS	PHILADELPHIA
SLOMIANY, MD, WALTER P	WASHINGTON
SLOMPAK, MD, CAROL A	LEHIGH
SLOTHOUR, MD, EDWARD F	YORK
SLOTTER, TRACY L	STUDENT
SLOVAK, MD, JOHN P	LANCASTER
SLUHOCKI, DO, MARK	LUZERNE
SMAHA, MD, LYNN A	BRADFORD
SMALL, MD, GEORGE A	ALLEGHENY
SMALL, MD, RICHARD E	YORK
SMALL, MD, ROY S	LANCASTER
SMALLEY, MD, ARTHUR J	YORK
SMART, MD, LAWSON C	CRAWFORD
SMART, MD, PAUL E	MERCER
SMEAL, MD, WILLIAM E	CAMBRIA
SMELTZER, MD, KENNETH L	DAUPHIN
SMETANKA, CYNTHIA A	STUDENT
SMIDTAS, MD, RENALDAS A	MONTGOMERY
SMIGOCKI JR, MD, GENE C	LANCASTER
SMILEY, MD, JOSEPH W	DELAWARE
SMINK JR, MD, ROBERT D	DELAWARE
SMITH, MD, A MITCHELL	PHILADELPHIA
SMITH, MD, ABBY A	ALLEGHENY
SMITH, MD, ARTHUR E	PHILADELPHIA
SMITH, MD, ARTHUR K	PHILADELPHIA
SMITH, MD, BARTON L	BERKS
SMITH, MD, CATHY S	DELAWARE
SMITH, MD, CHARLES E	ALLEGHENY
SMITH, DO, COLEEN M	LANCASTER
SMITH, MD, DAVID A	DAUPHIN
SMITH, MD, DAVID A	BUCKS
SMITH, MD, DAVID G	PHILADELPHIA
SMITH, MD, DAVID L	BUCKS
SMITH, MD, DAVID R	MONTGOMERY
SMITH, MD, DENNIS R	UNION
SMITH, MD, DONALD H	NORTHAMPTON
SMITH, DO, DOUGLAS F	PHILADELPHIA
SMITH, MD, EARL B	ALLEGHENY
SMITH, MD, EDGAR C	DELAWARE
SMITH, MD, ELLEN G	DAUPHIN
SMITH, MD, EUGENE C	LANCASTER
SMITH, MD, GARY L	ALLEGHENY
SMITH, MD, GARY M	LUZERNE
SMITH, MD, GREGORY N	ALLEGHENY
SMITH, MD, GREGORY T	ALLEGHENY
SMITH, MD, IAN D	LANCASTER
SMITH, MD, IVAN S	MONTGOMERY
SMITH, MD, JACK D	WESTMORELAND
SMITH, MD, JAMES K	ALLEGHENY
SMITH, MD, JAMES M	CUMBERLAND
SMITH, MD, JAMES W	YORK
SMITH, MD, JAN D	ALLEGHENY
SMITH, MD, JERE P	LEHIGH
SMITH, JOANNA M	STUDENT
SMITH, MD, JOHN M	YORK
SMITH, MD, JOHN R	ALLEGHENY
SMITH, MD, JOHN W	ALLEGHENY
SMITH, MD, JOSEPH L	MONTOUR
SMITH, MD, KAIGHN	PHILADELPHIA
SMITH, MD, LAURANCE D	MONTGOMERY
SMITH, MD, LINDA A	ALLEGHENY
SMITH, MD, LINDA M	LEBANON
SMITH, MD, MARIA B	DELAWARE
SMITH, MD, MARY L	MONTGOMERY
SMITH, MD, MICHAEL F	PHILADELPHIA
SMITH, MD, MONICA E	DELAWARE
SMITH, MD, RAYMOND L	BERKS
SMITH, MD, ROBERT C	ALLEGHENY
SMITH, MD, ROBERT G	WARREN
SMITH, MD, ROBERT W	MONTGOMERY
SMITH, MD, ROGER M	MONTGOMERY
SMITH, MD, RONALD E	BERKS
SMITH, MD, RUSSELL C	CHESTER
SMITH, MD, SANDRA J	DAUPHIN
SMITH, MD, STEPHEN H	BUCKS
SMITH, MD, STEVEN D	PHILADELPHIA
SMITH, MD, THOMAS C	LYCOMING
SMITH, MD, THOMAS W	JEFFERSON
SMITH, MD, TIMOTHY C	PHILADELPHIA
SMITH, MD, VICTORIA T	BLAIR
SMITH, MD, WALTER E	ALLEGHENY
SMITH, MD, WALTER K	WESTMORELAND
SMITH, MD, WARREN S	ALLEGHENY
SMITH, MD, WILLIAM D	DELAWARE
SMITH, MD, WILLIAM P	CAMBRIA
SMITH, MD, WILLIAM T	ALLEGHENY
SMITH JR, MD, B DAVISON	DELAWARE
SMITH JR, MD, BENJAMIN V	ALLEGHENY
SMITH JR, MD, CHESTER L	MONROE
SMITH JR, MD, EDGAR C	PHILADELPHIA
SMITH JR, MD, GEORGE S	LEHIGH
SMITH JR, MD, H ALEX	LUZERNE
SMITH JR, MD, J STANLEY	DAUPHIN
SMITH JR, MD, JAMES W	BEAVER
SMITH JR, MD, MORGAN T	MONTGOMERY
SMITH JR, MD, PERRY C	WASHINGTON
SMITH JR, MD, ROSS H	ALLEGHENY
SMOLAR, MD, BEN R	ALLEGHENY
SMOLEN, DO, DANIEL A	DELAWARE
SMOLINSKI, DO, WILLIAM J	LEHIGH
SMOLKO, MD, JAMES M	YORK
SMOLKO, MD, JAMES R	YORK
SMOOKE, MD, MARK E	MIFFLIN/JUNIATA
SMOOKLER, AMY E	STUDENT
SMOYER, MD, RONALD L	CAMBRIA
SMULLENS, MD, STANTON N	PHILADELPHIA
SMYTH, MD, LAWRENCE T	NORTHAMPTON
SMYTHE, MD, PEGGY A	ALLEGHENY
SNEDDEN, MD, HAL E	MONTGOMERY
SNEDDEN, MD, MICHAEL H	MONTGOMERY
SNEERINGER, DO, THOMAS D	CRAWFORD
SNEFF, MD, EUGENE M	BLAIR
SNELLING, MD, LESLEY	PHILADELPHIA
SNIDER, MD, B LEONARD	ERIE
SNIDER, MD, CAMERON F	ALLEGHENY
SNITZER, MD, ARNOLD J	ALLEGHENY
SNITZER, MD, LEWIS S	CAMBRIA
SNODGRASS JR, MD, W HOMER	ALLEGHENY
SNOOK, MD, MARY ELLEN	PHILADELPHIA
SNOW, MD, LAURENCE H	PHILADELPHIA
SNOW, RENEE E	STUDENT
SNOW, MD, ROSS A	ERIE
SNOWBERGER, DO, TINA M	WASHINGTON
SNOWMAN, PATRICK J	STUDENT
SNOWMAN, MD, WHITNEY R	WESTMORELAND
SNYDER, DO, ALLAN R	BUCKS
SNYDER, MD, ALLEN P	ALLEGHENY
SNYDER, MD, BARRY J	CLARION
SNYDER, MD, BARRY J	BUCKS
SNYDER, MD, DAVID C	BEAVER
SNYDER, MD, DIEHL M	LEBANON
SNYDER, MD, EARL J	LEBANON
SNYDER, MD, HARRY D	MONTGOMERY
SNYDER, MD, HENRY R	YORK
SNYDER, MD, JOHN M	NORTHAMPTON
SNYDER, LORI S	STUDENT
SNYDER, MD, MARVIN C	CARBON
SNYDER, MD, RANDALL W	LACKAWANNA
SNYDER, DO, RICHARD K	LEHIGH
SNYDER, MD, RICHARD L	LANCASTER
SNYDER, MD, RICHARD W	MONTGOMERY
SNYDER, MD, ROBERT L	NORTHAMPTON
SNYDER, DO, SAMUEL K	PHILADELPHIA
SNYDER, MD, STANLEY	LEHIGH
SNYDER, MD, STUART	PHILADELPHIA
SNYDER, SUSAN L	STUDENT
SNYDER III, MD, HOWARD MCC	PHILADELPHIA
SNYDER JR, MD, CHARLES F	NORTHAMPTON
SNYDER JR, MD, CHARLES P	WESTMORELAND
SNYDERMAN, MD, CARL H	ALLEGHENY
SNYDERMAN, MD, RUBEN	ALLEGHENY
SNYDMAN, MD, LEONARD	PHILADELPHIA
SO, MD, ANTHONY D	PHILADELPHIA

SOBEL, MD, JOSEPH B	STUDENT
SOBEL, MD, RICHARD M	PHILADELPHIA
SOBEL, MD, ROSE M	PHILADELPHIA
SOBER, MD, DIANE M	ALLEGHENY
SOBIERAJ, MD, KRZYSZTO M	NORTHAMPTON
SOBIESKI, MD, JOSEPH T	CAMBRIA
SOBLE, MD, MARC G	YORK
SOBOTA, MD, BRET T	STUDENT
SOCRATES, MD, JESS U	YORK
SODEMAN, MD, WILLIAM A	PHILADELPHIA
SOETENS, MD, FILIEP M	ALLEGHENY
SOFFE, MD, ALVIN M	PHILADELPHIA
SOFFER, MD, MARVIN	PHILADELPHIA
SOFFER, MD, STEPHEN R	BERKS
SOFFIETTI, MD, JOHN H	BUTLER
SOFFRONOFF, MD, PIERCE	ALLEGHENY
SOIFER, DO, NEAL E	LACKAWANNA
SOIKA, MD, CHRISTOPHER W	POTTER
SOISSON JR, MD, FERDINAND L	CAMBRIA
SOKALCHUK, MD, ANDREW	PHILADELPHIA
SOKIL, MD, ALEXIS BOHDAN	PHILADELPHIA
SOKOL, MD, JOEL H	DELAWARE
SOKOL, MD, MICHAEL C	MONTGOMERY
SOKOLOSKI, PAUL W	STUDENT
SOLA, MD, JULIO I	CUMBERLAND
SOLAN, MD, JAMES A	WESTMORELAND
SOLAN, MD, MERRILL J	DELAWARE
SOLANKI, MD, INDUKUMAR M	PHILADELPHIA
SOLANKI, MD, PADMANAND Y	DELAWARE
SOLANO JR, MD, FRANCIS X	ALLEGHENY
SOLBERG, MD, BYRNE L	DELAWARE
SOLI, MD, SOLEIMAN M	PHILADELPHIA
SOLIC, MD, JOHN J	CENTRE
SOLIMAN, MD, EZZAT M	WYOMING
SOLIN, MD, LAWRENCE J	PHILADELPHIA
SOLIS, MD, J ANDREW	BUCKS
SOLIT, DAVID B	STUDENT
SOLIT, MD, RICHARD L	PHILADELPHIA
SOLL, MD, DAVID B	PHILADELPHIA
SOLL, MD, STEPHEN M	PHILADELPHIA
SOLLENBERGER, MD, LARRY L	DAUPHIN
SOLLENBERGER, MD, LAURA B	BLAIR
SOLLENBERGER, DO, STANTON E	FRANKLIN
SOLLER, MD, HERBERT I	DAUPHIN
SOLOMON, MD, CYNTHIA A	LUZERNE
SOLOMON, MD, DANIEL J	MONROE
SOLOMON, DO, DENNIS R	PHILADELPHIA
SOLOMON, MD, ELIAS M	LANCASTER
SOLOMON, MD, MARK P	PHILADELPHIA
SOLOMON, MD, SAMUEL J	YORK
SOLOMON, MD, SOLOMON D	ADAMS
SOLOSHAR, LESLIE B	STUDENT
SOLOT, DO, JERALD A	ALLEGHENY
SOLOTOFF, MD, STEPHEN A	MONTGOMERY
SOLOW, MD, EDWARD A	PHILADELPHIA
SOLOW, MD, IRWIN A	ALLEGHENY
SOLTER, MD, ALAN W	ALLEGHENY
SOMA, MD, JOSEPH J	LACKAWANNA
SOMASUNDARAM, MD, ANASUYA	NORTHAMPTON
SOMERS, MD, DEBRA LYNNE	PHILADELPHIA
SOMERS, MD, ERNEST E	FRANKLIN
SOMERS, MD, HERBERT J	PHILADELPHIA
SOMERS, MD, KEITH S	ALLEGHENY
SOMERS, MD, LAURENCE A	PHILADELPHIA
SOMERS, MD, ROBERT G	PHILADELPHIA
SOMERS, MD, WILLIAM R	LYCOMING
SOMERSET, DO, WILLIAM J	ALLEGHENY
SOMMA, MD, RICHARD M	LUZERNE
SOMMER, MD, DEBORAH L	ALLEGHENY
SOMMER, MD, JOHN T	DELAWARE
SOMMER, MD, VICKI M	BLAIR
SOMMERFELD, MD, JAMES P	LAWRENCE
SONBOLIAN, MD, NASSER	ALLEGHENY
SONDER, MD, HESTER M	PHILADELPHIA
SONDER, MD, MAX J	PHILADELPHIA
SONG, MD, SANG W	BUCKS
SONG, MD, STEVEN S	MONTGOMERY
SONG, SUNG W	STUDENT
SONG, MD, YOUNG J	WESTMORELAND
SONG, MD, YUNG-DOO	PHILADELPHIA
SONNE, MD, JOHN C	PHILADELPHIA
SONNEBORN, MD, DUANE G	PHILADELPHIA
SONSINI, MD, GREGG A	MONTGOMERY
SONTCHI, SIOBHAN L I	STUDENT
SOPCHAK, MD, MICHAEL A	YORK
SOPKY, BERNARD J	STUDENT
SORARUF IV, MD, L PETER	CHESTER
SORBER, MD, WILLIAM A	LYCOMING
SORDONI, SUSAN F	STUDENT
SORENSEN, MD, ALFRED L	WASHINGTON
SORIANO, MD, CLAVER S	ALLEGHENY
SORIANO JR, MD, MANUEL G	ELK/CAMERON
SORICELLI, MD, RHONDA L	PHILADELPHIA
SORICELLI, MD, RICHARD R	DELAWARE
SORKIN, MD, HARDY L	CHESTER
SOROKANICH JR, MD, STEPHEN	LACKAWANNA
SOROKANICH SR, MD, STEPHEN	LACKAWANNA
SOROKIN, MD, RACHEL B	PHILADELPHIA
SOROUSH, MD, AZAM	PHILADELPHIA
SORR, MD, EDWARD M	ALLEGHENY
SORRENTINO, DAVID F	STUDENT
SORRESSO, MD, DENNIS P	DAUPHIN
SORTINO, MD, ANTONIO	ALLEGHENY
SOSIS, MD, ARTHUR C	LEHIGH
SOSS, JASON R	STUDENT
SOSS, DO, MURRAY C	PHILADELPHIA
SOTELO, MD, AUGUSTO	WESTMORELAND
SOTEREANOS, MD, DEAN G	ALLEGHENY
SOTOODEHFAR, MD, RAHIM	ALLEGHENY
SOTOS, MD, L NICHOLAS	ARMSTRONG
SOTOS, MD, PETER N	ARMSTRONG
SOTOS, MD, STEVEN N	ALLEGHENY
SOTTILE, MD, ELISA M	PHILADELPHIA
SOTUS, MD, PETER C	MERCER
SOUAID JR, MD, VICTOR J	ERIE
SOUDER, MD, C LAWRENCE	LEHIGH
SOUDER, MD, FRANCIS R	BUCKS
SOUDER, MD, RONALD L	BUCKS
SOUDERS, MD, THOMAS B	BERKS
SOUILLIARD, MD, DONALD H	BUCKS
SOUNDARARAJAN, MD, RANGANATHA	LYCOMING
SOUNDARARAJAN, VIDYA	STUDENT
SOUSER, MD, ROSLYN C	MONTGOMERY
SOUTHARD, MD, RICHARD N	CRAWFORD
SOVETSKY, DO, CHARLES L	DELAWARE
SOWKA, MD, LAWRENCE R	ALLEGHENY
SPADARO, MD, DONNA P	VENANGO
SPAGNOLETTI, MD, LOUIS	PHILADELPHIA
SPAGNOLI, MD, MARIE V	ADAMS
SPAHN, DO, KREIG A	CRAWFORD
SPAHR, MD, ROBERT C	MONTOUR
SPANARD, MD, RUSSELL A	ALLEGHENY
SPANOGIANS, MD, ANGELO J	WASHINGTON
SPEACE, MD, GEORGE F	LUZERNE
SPEAKE, MD, MARK R	UNION
SPEAR, MD, BARBARA A	BUCKS
SPEARS, MD, LAURA S	YORK
SPEARS, MD, PAUL F	YORK
SPEASE, DO, CARL R	MIFFLIN/JUNIATA
SPECTER, MD, JANET S	PHILADELPHIA
SPECTOR, MD, GUS	CHESTER
SPECTOR, DO, HOWARD L	LUZERNE
SPEEDY, MD, HARRY W	WESTMORELAND
SPEERS, MD, HERBERT K	BUCKS
SPEEZ, MD, NANCY	INDIANA
SPEICHER, MD, JULIE M	LACKAWANNA
SPEICHINGER, MD, JAMES P	LYCOMING
SPELLER, MD, J FINTON	PHILADELPHIA
SPELLMAN, MD, WILLIAM H	MONTGOMERY
SPENCE, MD, MICHAEL R	PHILADELPHIA
SPENCE, DO, MICHAEL W	MONROE
SPENCER, MD, DONALD LYNN	CHESTER
SPENCER, MD, H NEWTON	DELAWARE
SPENCER, MD, JAMES H	LAWRENCE
SPENCER, MD, JEANNE P	CAMBRIA
SPERBER, MD, DAVID E	LYCOMING
SPERLING, MD, DAVID M	ALLEGHENY
SPERLING, MD, HERBERT V	ALLEGHENY
SPERRAZZA, MD, JIM C	STUDENT
SPIEGEL, MD, EDWARD P	BUCKS
SPIEGEL, MD, JOSEPH R	PHILADELPHIA
SPIELBERG, MD, STEPHEN P	MONTGOMERY
SPIELMAN, MD, SCOTT R	PHILADELPHIA
SPIELVOGEL, MD, RICHARD L	PHILADELPHIA
SPIGNER, MD, DONALD W	DAUPHIN
SPIKER, MD, DUANE G	ALLEGHENY
SPILSBURY, MD, PAUL R	MONTOUR
SPINA, MD, CARMEN M	BUTLER
SPINA, MD, NANCY R	BUTLER
SPINA JR, MD, JOSEPH	DELAWARE
SPINGOLA, MD, CHARLES E	BUTLER
SPINNEY, MD, CARMEN E	LYCOMING
SPINO, MD, PASCAL D	WESTMORELAND
SPINOLA, MD, ANTHONY	STUDENT
SPINUZZA, MD, THOMAS J	FAYETTE
SPIRITOS, MD, MICHAEL D	MONTGOMERY
SPITLER III, MD, WILLIAM M	LANCASTER
SPITZ, MD, EUGENE B	PHILADELPHIA
SPITZ, MD, LAWRENCE K	PHILADELPHIA
SPITZER, DO, IRA E	BUCKS
SPITZER, MD, LAURENCE J	PHILADELPHIA
SPITZER, MD, STANLEY	PHILADELPHIA
SPIVACK, MD, JACK	BUCKS
SPLAIN, DO, DENNIS J	LEHIGH
SPOCK, MD, NICHOLAS	NORTHMBRLAND
SPOEHR, MD, LUTHER W	ALLEGHENY
SPOLL, DO, EDWARD A	NORTHAMPTON
SPONSLER, REBECCA L	STUDENT
SPOTTS, MD, DOUGLAS A	DAUPHIN
SPOTTS, MD, RICKE L	LEBANON
SPRANDIO, MD, JOHN D	PHILADELPHIA
SPRATT, MD, CHARLES E	MONTGOMERY
SPRATT, MD, ROBERT H	MONTGOMERY
SPRING, MD, DEBORAH A	LUZERNE
SPRINGER, MD, JAY M	BUCKS
SPRINGER III, MD, ROBERT M	LANCASTER
SPURRIER, MD, DAVID J	CUMBERLAND
SPYROPOULOS, DO, GEORGE N	CHESTER
SQUADRITO JR, MD, JAMES F	MONTGOMERY
SRIDHARA, MD, C R	PHILADELPHIA
SRIDHARAN, MD, MALINI	PHILADELPHIA
SRIHARSHA, MD, PATALAM S	COLUMBIA
SRINIVASAGAM, MD, NARASIMMAN	ALLEGHENY
SRINIVASAN, MD, VENKATRAMAN	ALLEGHENY
SRIVASTAVA, MD, BRIJ B	DELAWARE
SRIVASTAVA, MD, POONAM	NORTHMBRLAND
SRODES, MD, CHARLES H	ALLEGHENY
SROUJI, MD, MAURICE N	PHILADELPHIA
SROUJI, MD, SAMIR J	DAUPHIN
SROUR, MD, JAMES W	YORK
ST ANDRE, MD, MARY L	ALLEGHENY
STAAB, MD, JEFFREY P	ALLEGHENY
STAAS JR, MD, WILLIAM E	PHILADELPHIA
STABILE, MD, JEROME G	NORTHAMPTON
STABLER, MD, CRAIG L	LYCOMING
STACHER, MD, ERIC D	GREENE
STACHOWIAK, MD, EDWARD J	LUZERNE
STACK, MD, WILLIAM T	PHILADELPHIA
STAEBLER, MD, ROBIN J	BERKS
STAFFORD, MD, CALVIN R	DELAWARE
STAFFORD, DO, DOUGLAS T	MONTGOMERY
STAFFORD, MD, PERRY W	PHILADELPHIA
STAFFORD, MD, REGIS W	ALLEGHENY
STAHLFELD, MD, KURT R	ALLEGHENY
STAHLMAN, MD, FREDERICK B	CLARION
STAHLMAN, MD, ROY A	DELAWARE
STAHLNECKER, MD, C STEPHEN	DELAWARE
STAINBACK, MD, WILLIAM C	MONTGOMERY
STALLINGS, MD, VIRGINIA A	PHILADELPHIA
STALTER, MD, RALPH J	ALLEGHENY
STAMAN, MD, HARRY	ALLEGHENY
STAMATAKOS, MD, MICHAEL J	LEHIGH
STAMBAUGH, MICHAEL D	STUDENT
STAMM, MD, BARRY D	ERIE
STANCIC, MD, SARAY	DAUPHIN
STANCOMBE, MD, WESLEY R	NORTHAMPTON
STANEK, MD, MARJORIE A	PHILADELPHIA
STANEK, MD, ROBERT	PHILADELPHIA
STANGER, MD, ROBERT H	ALLEGHENY
STANISH, MD, FRANK X	ALLEGHENY
STANISLAW, MD, SCOTT R	MONTOUR
STANKIEWICZ, MD, EDWARD R	DELAWARE
STANKIEWICZ, MD, RUSSELL J	UNION
STANKOSKI, MD, JOHN A	LUZERNE
STANKOVIC, MD, LJUBISA	DAUPHIN
STANKOVICH, MARA J	STUDENT
STANLEY, MD, CHARLES A	PHILADELPHIA
STANTON, MD, DAVID C	PHILADELPHIA
STANTON, MD, ELIZABETH L	BERKS
STANTON JR, MD, JAMES N	ALLEGHENY
STANTON JR, MD, JOHN J	PHILADELPHIA
STAPFER, MARIA V	STUDENT
STAPLES, MD, HERMAN D	DELAWARE
STAPOR, MD, DAVID J	ALLEGHENY
STAPP, MD, HARRIET L	MONTGOMERY
STAR, MD, ANDREW M	MONTGOMERY
STARER, MD, LARRIMORE J	DELAWARE
STARK, MD, BRUCE I	CHESTER
STARKEY, MD, RALPH H	MONTOUR
STAROS, MD, ERIC B	DELAWARE
STARR, MD, ROBERT	ALLEGHENY
STARR, MD, STUART E	PHILADELPHIA
STARRELS, MD, MICHAEL E	BUCKS
STARRELS, MD, SIDNEY H	PHILADELPHIA
STARUNKO, MD, BASILIO	ALLEGHENY
STARZ, MD, TERENCE W	ALLEGHENY
STARZL, MD, THOMAS E	ALLEGHENY
STASIK JR, MD, JOHN J	LEHIGH
STASSI, MD, JOHN	PHILADELPHIA
STATLER, JOHN D	STUDENT
STAUB, MD, ALICE W	PHILADELPHIA
STAUB, DO, DEBRA A	LEBANON
STAUDT, MD, SUSAN R	PHILADELPHIA
STAUFFER, BRIAN L	STUDENT
STAUFFER, MD, HAROLD E	LANCASTER
STAUFFER, MD, JAMES D	LEBANON
STAUFFER, PAUL R	STUDENT
STAUFFER, MD, RICHARD A	NORTHAMPTON
STAUFFER, MD, STANLEY S	NORTHAMPTON
STAVRIDES, MD, ALEXANDER	ALLEGHENY
STAVRIDES, MD, MARCIA M	ALLEGHENY
STAYER, MD, GLENN A	MONTOUR
STECCO, KATHRYN	STUDENT
STECHISON, MD, MICHAEL T	ALLEGHENY
STECHSCHULTE JR, MD, DONALD W	UNION
STECKEL, MD, ALAN J	ALLEGHENY
STECKEL, MD, DONALD C	UNION
STEEL, MD, HOWARD H	PHILADELPHIA
STEELE, MD, JOHN E	CARBON
STEELE, MD, JOHN F	MERCER
STEELE, DO, KIRTH W	NORTHAMPTON
STEELE, MD, LOGAN H	ALLEGHENY
STEELE, MD, RICHARD J	PHILADELPHIA
STEELMAN, DO, MICHAEL T	YORK
STEEN, MD, C A EDWARD	MONTOUR
STEEN, MD, OLIVER T	ALLEGHENY
STEERMAN, MD, PAUL H	PHILADELPHIA
STEFANELLI, MD, JAMES L	LACKAWANNA
STEFANELLI, MD, JOANN G	ALLEGHENY
STEFANICK, DO, PATTI A	CAMBRIA
STEFANIK, MD, DAVID	CAMBRIA
STEFANKO, KAREN E	STUDENT
STEFANOVSKI, MD, NICK	ERIE
STEFANYSZYN, MD, MARY A	PHILADELPHIA
STEFENELLI, DO, GEORGE E	FRANKLIN
STEFFENSEN, MD, DAVID O	WESTMORELAND
STEGURA, MD, BARNEY A	LUZERNE
STEIGERWALT, MD, JOHN L	MONTGOMERY
STEIKER, MD, DANIEL D	PHILADELPHIA
STEIN, ALAN D	STUDENT
STEIN, MD, ALAN H	CAMBRIA
STEIN, MD, ANTHONY	PHILADELPHIA
STEIN, MD, ARTHUR V	LEHIGH
STEIN, MD, BETSY A	PHILADELPHIA
STEIN, MD, BRADLEY D	ALLEGHENY
STEIN, MD, ELEANOR R	DAUPHIN
STEIN, MD, ETHAN A	ALLEGHENY
STEIN, MD, FRANKLIN M	PHILADELPHIA
STEIN, MD, GEORGE N	PHILADELPHIA
STEIN, MD, HARMON C	BUCKS
STEIN, MD, HERBERT	PHILADELPHIA
STEIN, MD, HYMEN D	PHILADELPHIA
STEIN, MD, IRVIN	PHILADELPHIA
STEIN, DO, JACK M	PHILADELPHIA
STEIN, MD, RICHARD N	NORTHAMPTON
STEIN, MD, ROBERT B	PHILADELPHIA
STEIN, MD, ROBERT S	NORTHAMPTON
STEIN, MD, STANLEY I	NORTHAMPTON
STEIN, MD, THOMAS M	ALLEGHENY
STEIN, MD, WALTER	BERKS
STEIN JR, MD, DONALD B	DELAWARE
STEINBERG, MD, ABRAAM	ALLEGHENY
STEINBERG, MD, DEAN A	PHILADELPHIA
STEINBERG, MD, MARVIN E	PHILADELPHIA
STEINBERG, MD, MICHAEL L	ALLEGHENY
STEINBERG, MD, NATHAN	PHILADELPHIA
STEINBOOK, MD, MELVIN	NORTHAMPTON
STEINBRINK, MD, WILLIAM H	ERIE
STEINDEL, MD, CARL R	LACKAWANNA
STEINER, MD, ROBERT M	PHILADELPHIA
STEINFELD, MD, RICHARD I	MERCER
STEINFIELD, MD, PAUL H	PHILADELPHIA
STEINGARD, MD, JOSEPH J	PHILADELPHIA
STEINMAN, MD, ARNOLD M	ALLEGHENY
STEINMAN, MD, ROBERT C	LANCASTER
STEINMETZ III, MD, CHARLES G	PHILADELPHIA
STEINMEYER JR, MD, HARRY H	MONTGOMERY
STEINOUR, MD, THOMAS A	FRANKLIN
STEKERT, MD, RUTH	BUCKS
STELLA, MD, HECTOR J	DELAWARE
STELMACH, MD, JOHN P	BERKS
STELMACH, MD, PAUL	BERKS
STELMACH, MD, PETER	BERKS
STELMACH, MD, W PETER	BERKS
STELTS, MD, STEVEN R	YORK
STELZER, MD, FREDERIC A	LEHIGH
STEM JR, MD, THEODORE B	WESTMORELAND
STEMMLER, MD, MARGARET M	PHILADELPHIA
STEMPKOWSKI JR, MD, JOSEPH J	MONTOUR
STEN, MD, JON D	NORTHMBRLAND
STENBERG, MD, ROBERT G	CAMBRIA
STENCLER, MD, KERRY A	BUCKS
STENE, MD, JOHN K	DAUPHIN
STENGEL, MD, ROBERT J	LANCASTER
STEPHAN, MD, PETER D	ALLEGHENY
STEPHAN, MD, THORSTEN	ALLEGHENY
STEPHENS JR, MD, HARRY W	LEHIGH
STEPHENSON, MD, JAMES B	CHESTER
STEPHENSON, MD, KEITH R	ERIE
STEPHENSON, MD, ORLANDO K	PERRY
STEPHENSON, MD, PATRICIA A S	BUCKS
STEPHENSON JR, MD, EDWARD R	DAUPHIN
STEPPACHER, MD, LESTER G	PHILADELPHIA
STEPT, MD, LARRY L	ALLEGHENY
STEPT, MD, LEONARD A	ALLEGHENY
STEPT, MD, RAYMOND	ALLEGHENY
STEPT, MD, WILLIAM J	ALLEGHENY
STERLING, MD, NANCY I	DAUPHIN
STERN, ALAN G	STUDENT
STERN, MD, JOHN J	PHILADELPHIA
STERN, MD, LILLIAN H	PHILADELPHIA
STERN, MD, ROBERT M	ALLEGHENY
STERNBURG, MD, JON K	WAYNE/PIKE
STERNLIEB, MD, JONATHAN M	MONTGOMERY
STERNLIEB, MD, SANFORD B	LUZERNE
STETZ, DO, DREW J	HUNTINGDON
STEVEN, MD, JAMES M	PHILADELPHIA
STEVENS, DO, PHILIP J	DELAWARE
STEVENS, MD, ROBERT G	LYCOMING
STEVENSON, MD, KATHLEEN M	DELAWARE
STEVENSON, MD, RICHARD D	MONTGOMERY
STEVER, DO, MICHAEL R	INDIANA
STEWARD, MD, JOANNE A	LEHIGH
STEWARD JR, MD, ROBERT E	CLEARFIELD
STEWART, MD, DOUGLAS P	WESTMORELAND
STEWART, MD, MERVIN S	ALLEGHENY
STEWART, MD, MICHAEL J	PHILADELPHIA
STEWART, MD, MICHAEL P	LACKAWANNA
STEWART, MD, RICHARD P	DAUPHIN
STEWART, MD, WILLIAM D	ALLEGHENY
STEWART, MD, WILLIAM W	MONTGOMERY
STEWART III, DO, JOSEPH H	FRANKLIN
STEWART JR, MD, WILLIAM G	MONTGOMERY
STICK, MD, WESLEY D	YORK
STIEBER, MD, SCOTT F	LANCASTER
STIEG, MD, PHILIP D	LEBANON
STIEGEL, MD, ROBERT M	BEAVER
STIERSTORFER, MD, MAX J	LEHIGH
STIFFEL, MD, ARTHUR	PHILADELPHIA
STIFFEL, MD. JERRY	PHILADELPHIA
STILE, MD, SABATO A	WESTMORELAND
STILL, DO, MARGARET M	MONTOUR
STINE, MD, AMY R	ALLEGHENY
STINE JR, MD, LESTER E	ALLEGHENY
STINELY, MD, REGIS W	WASHINGTON
STINEMAN, MD, MARGARET G	PHILADELPHIA
STISH, MD, EUGENE R	LUZERNE
STISH JR, MD, ANTHONY G	LUZERNE
STITT, MD, DONALD G	MERCER
STOCKER, MD, KEVIN D	WASHINGTON
STOCKMANN, MD, PAUL T	PHILADELPHIA
STOCKSTILL, MD, TODD F	ALLEGHENY
STODDARD, MD, NEIL W	LEHIGH
STOFMAN, MD, GUY M	ALLEGHENY
STOKAR, MD, LAWRENCE M	ALLEGHENY
STOKEN, MD, DREW J	CUMBERLAND
STOKER, MD, JOHN W	BLAIR
STOKES, MD, LOUIS C	CHESTER
STOKES, MD, R FRASER	FAYETTE
STOKES, MD, RANJAN	PHILADELPHIA
STOKES, MD, WAYNE L	CENTRE
STOLAR, MD, NEAL M	PHILADELPHIA

STOLLER, MD, RONALD G	ALLEGHENY
STOLOFF, MD, IRWIN L	PHILADELPHIA
STOLTZFUS, MD, ELAM R	UNION
STOLZ, MD, JOHN C	BERKS
STOLZ, MD, JONATHAN L	BERKS
STOLZ, MD, PAUL K	BERKS
STOLZ, DO, RALPH E	LEHIGH
STOLZER, MD, BERTRAND L	ALLEGHENY
STONE, MD, DAVID A	ALLEGHENY
STONE, DO, DONALD J	COLUMBIA
STONE, MD, HRANT H	PHILADELPHIA
STONE, MD, JEFFREY D	ALLEGHENY
STONE, MD, ROBERT K	MONTGOMERY
STONE, MD, WALKER H	LYCOMING
STONE JR, MD, CHARLES S	ALLEGHENY
STONER, MD, JOHN C	DAUPHIN
STONER, MD, JOHN G	YORK
STONER, MD, MAX A	DAUPHIN
STONER, MD, PAUL S	DAUPHIN
STONER, MD, ROBERT E	LANCASTER
STONESIFER, DO, TIMOTHY B	FRANKLIN
STONITSCH, MD, FRANK C	ERIE
STOREY, MD, MARK A	ALLEGHENY
STORM, MD, CHARLES T	DELAWARE
STORM, MD, RANDLE H	MONTOUR
STORNIOLO, MD, COSIMO N	YORK
STORY, MD, NANCY S	LYCOMING
STOTLER, MD, CHARLES W	CAMBRIA
STOTT, MD, GERALDINE A	YORK
STOUDT, MD, DONALD E	BERKS
STOUDT, MD, K DONALD	MERCER
STOUDT, DO, KATHY J	BERKS
STOUFFER JR, MD, VANCE R	YORK
STOUT, JOYCE E	STUDENT
STOUT, MD, RICHARD R	ALLEGHENY
STOUT, MD, WILLIAM J	LANCASTER
STOVER, MD, DONALD L	CAMBRIA
STOWELL, MD, JOSEPH M	BLAIR
STRACCI, DO, PETER F	ALLEGHENY
STRAKA, MD, JOHN A	ALLEGHENY
STRALEY, MD, RICHARD K	LYCOMING
STRAMAT, MD, JOHN M	ALLEGHENY
STRANATHAN, MD, CHRISTOPHER A	VENANGO
STRANG, MD, CLYDE A	YORK
STRANG, MD, DAVID J	LUZERNE
STRANG, MD, JOHN E	MONTGOMERY
STRANGARITY, MD, JOSEPH W	LANCASTER
STRATIS, MD, JOHN P	DAUPHIN
STRATTON, MD, HENRY A	PHILADELPHIA
STRATTON, MD, ROBERT D	ERIE
STRAUSBAUGH, MD, JANET T	YORK
STRAUSBAUGH, MD, RICHARD	YORK
STRAUSE JR, MD, HAROLD L	BERKS
STRAUSS, MD, JAY E	NORTHAMPTON
STRAUSS, MD, RICHARD E	BUCKS
STRAUSS, MD, ROBERT D	LEHIGH
STRAVINO, MD, VINCENT D	NORTHAMPTON
STREET, MD, THOMAS F	LUZERNE
STREISFELD, MD, DAVID L	LEBANON
STREISFELD, MD, NEIL T	PHILADELPHIA
STRELEC, MD, STEPHEN R	ALLEGHENY
STRENGE, MD, HENRY J	PHILADELPHIA
STRENIO, MD, JONATHAN S	ALLEGHENY
STREUBERT, MD, GEORGE E	NORTHAMPTON
STRIAR, MD, JEFFREY H	MONTGOMERY
STRICKLAN, MD, DAVID K	PHILADELPHIA
STRICKLAND, MD, MARY L	MONTOUR
STRICKLER, MD, JANE A M	CENTRE
STRIMLAN, MD, C VAUGHN	ALLEGHENY
STRITTMATTER, MD, JOHN M	LANCASTER
STROBEL JR, MD, GEORGE E	BERKS
STROBL, MD, PHILIP H	ALLEGHENY
STROCK, MD, BRADFORD K	DAUPHIN
STROCKBINE, MD, MELVIN F	YORK
STROHLEIN, MD, STEPHEN S	MONROE
STRONG, MD, GEORGE H	PHILADELPHIA
STRONG, MD, THERESSA B	ALLEGHENY
STRONG III, MD, MICHAEL D	PHILADELPHIA
STRONY JR, MD, RONALD S	STUDENT
STROUD, MD, HILARY A	ALLEGHENY
STROWHOUER, DO, WILLIAM J	DELAWARE
STROZ, MD, MARGARET M	CHESTER
STRUBBE, MD, KENNETH	YORK
STRUMIA, MD, PAUL V	MONTGOMERY
STRUMPH, MD, PAUL S	ALLEGHENY
STRUNK, MD, THOMAS J	CAMBRIA
STRUNK, MD, WILLIAM M	NORTHAMPTON
STRYKER, MD, ALLAN K	LYCOMING
STRYKER, MD, SEAN A	ALLEGHENY
STRZELECKI, MD, ZIGMUND F	BUCKS
STUART, MD, JOHN A	ALLEGHENY
STUART, MD, JOHN C	ALLEGHENY
STUART, MD, THOMAS J	LANCASTER
STUART, EXEC SEC, MD, ROBERT B	ERIE
STUBA, MD, STELLA	MONTGOMERY
STUCCIO, MD, DOMINICK A	LUZERNE
STUCCIO, MD, JOSEPH J	LUZERNE
STUDDIFORD, MD, JAMES S	PHILADELPHIA
STUDER, MD, SEAN M	PHILADELPHIA
STUGAN, MD, ANTHONY J	PHILADELPHIA
STULL, MD, MARK W	LANCASTER
STUMACHER, MD, RUSSELL J	PHILADELPHIA
STUPI, MD, ANGELA M	ALLEGHENY
STUPNIKER, MD, SONIA	PHILADELPHIA
STURM, MD, PATRICK W	BEAVER
STURM JR, MD, CHARLES F	ALLEGHENY
STURMAN, MD, MARTIN F	MONTGOMERY
STUTMAN, MD, FRED A	PHILADELPHIA
STUZIN, MD, NINA E	PHILADELPHIA
STYLER, MD, MICHAEL J	PHILADELPHIA
STYPULA, MD, MARK O	ALLEGHENY
STYPULA, MD, RICHARD W	MERCER
SU, MD, ALLEN D	YORK
SU, MD, LANG-PAO	LACKAWANNA
SU, MD, SEAN	DAUPHIN
SU, MD, SHYH-MIN	ALLEGHENY
SUAN, MD, ERIC P	DAUPHIN
SUAREZ, MD, RAMON U	LEBANON
SUAREZ, MD, SYLVIA M	ALLEGHENY
SUATONI JR, MD, FRANK J	ALLEGHENY
SUBACH, MD, BRIAN R	ALLEGHENY
SUBBIAH, MD, THEUARAYA N	BUTLER
SUBRAMANIAN, MD, THYAGARAJAN	ALLEGHENY
SUBRAMANY, MD, NARAYANASWAMY	ELK/CAMERON
SUBRAMANYAN, MD, SMITHA	PHILADELPHIA
SUCHESKI, BRIAN M	STUDENT
SUDOL, KATARZYNA S	STUDENT
SUERO, MD, RENE OSCAR	PHILADELPHIA
SUFI, RAMINDRAJIT S	STUDENT
SUGAR, MD, MIKLOS	DELAWARE
SUGARMAN, MD, SAMUEL	PHILADELPHIA
SUGIMOTO, GARY D	STUDENT
SUGIURA, MD, SUMIKO M	PHILADELPHIA
SUH, MD, EALL J	PHILADELPHIA
SUH, MD, SANG J	LACKAWANNA
SUK, MD, JIN H	VENANGO
SUKANICH, MD, KRIENGSAK	ALLEGHENY
SUKAROCHANA, MD, KAMTHORN	ALLEGHENY
SUKERKAR, MD, NITEEN N	FRANKLIN
SUKYS, MD, NANCY A	ALLEGHENY
SULECKI, MD, MATTHEW G	WESTMORELAND
SULEWSKI, MD, MICHAEL E	PHILADELPHIA
SULLIVAN, MD, CATHERINE B	PHILADELPHIA
SULLIVAN, MD, CHARLES C	PHILADELPHIA
SULLIVAN, DAVID M	STUDENT
SULLIVAN, MD, EDWARD M	DELAWARE
SULLIVAN, DO, JAMES J	YORK
SULLIVAN, MD, JOHN M	DAUPHIN
SULLIVAN, MD, KATHLEEN E	PHILADELPHIA
SULLIVAN, MD, LAWRENCE X	ALLEGHENY
SULLIVAN, MD, RICHARD A	MONTGOMERY
SULLIVAN, MD, ROBERT D	BLAIR
SULLIVAN, TERESA A	STUDENT
SULLIVAN, MD, WILLIAM H	PHILADELPHIA
SULLIVAN JR, MD, LAWRENCE X	ALLEGHENY
SULLUM, MD, JONATHAN C	LACKAWANNA
SULTAN, MD, WAMIQ S	PHILADELPHIA
SULTZ, DO, MARVIN E	PHILADELPHIA
SUMKIN, DO, JULES H	ALLEGHENY
SUMMERS, MD, KERMIT L	LANCASTER
SUMMERS, MD, RICHARD F	PHILADELPHIA
SUMMERTON, MD, SUSAN L	PHILADELPHIA
SUMMONS, MD, HOWARD J	BERKS
SUMNER, MD, ANDREW D	DAUPHIN
SUN, ANDREW N	STUDENT
SUN, ANTHONY Y	STUDENT
SUN, MD, DANNY D	NORTHAMPTON
SUN, MD, ELIZABETH A	MONTGOMERY
SUN, MD, EVELYN L	PHILADELPHIA
SUN, MD, HSIANG-CHUN	BERKS
SUN, MD, WILLIAM Z	PHILADELPHIA
SUNDARARAJAN, MD, RAJALAKSHMY	ALLEGHENY
SUNDARARAJAN, MD, SUNDARARAJAN	DAUPHIN
SUNDAY, MD, MICHAEL L	LACKAWANNA
SUNDERLIN JR, MD, FREDERICK S	MONTOUR
SUNDERMAN, MD, F WILLIAM	PHILADELPHIA
SUNDHEIM, MD, JAMES L	LACKAWANNA
SUNDT, MD, LINDA M	DELAWARE
SUNG, MD, CHUN M	ALLEGHENY
SUNG, MD, DUK I	ALLEGHENY
SUNG, MD, LEE H	WESTMORELAND
SUNG, MD, PAUL P	LAWRENCE
SUNSERI, MD, MARIA J	ALLEGHENY
SUPER, MD, LEONID E	PHILADELPHIA
SUPINSKI, MD, ROBERT S	POTTER
SUPPA, MD, OSVALDO S	ERIE
SUPPLE, MD, EDWARD W	LANCASTER
SUPROCK, MD, MARK D	ERIE
SURACI, MD, ALDO J	COLUMBIA
SURI, MD, SANJEEV	PHILADELPHIA
SURKIN, MD, MARC I	DELAWARE
SURMELI, SEDAT M	STUDENT
SUSANG-TALAMO, MD, BARBARA A	ALLEGHENY
SUSANN, MD, PHILIP W	ERIE
SUSI, MD, JOSEPH A	ERIE
SUSKI, DAVID A	STUDENT
SUSSMAN, MD, DAVID	LEHIGH
SUSSMAN, MD, MARCEL S	PHILADELPHIA
SUSSMAN, DO, MARK P	MONTGOMERY
SUSSMAN, MD, NATHAN	DAUPHIN
SUSSMAN, MD, SYLVIA	LEHIGH
SUTER, MD, HARRY J	LYCOMING
SUTER, MD, STANLEY C	LEBANON
SUTHERLAND, MD, ROBERT D	BERKS
SUTLIFF, MD, CARLENE S	DAUPHIN
SUTLIFF, MD, FREDERICK P	MONTGOMERY
SUTNICK, MD, ALTON I	PHILADELPHIA
SUTTER, DO, FRANCIS P	PHILADELPHIA
SUTTON, MD, A KEITH	HUNTINGDON
SUTTON, MD, CHARLES A	SOMERSET
SUTTON, MD, CHARLES S	DELAWARE
SUTTON, MD, LESLIE N	PHILADELPHIA
SUTTON, MD, PAUL L	MONTOUR
SUTTON JR, MD, EDWARD L	BUTLER
SUTTON JR, MD, JOHN C	BEAVER
SUVARNAKAR, MD, JAWAHAR N	JEFFERSON
SUWAN, MD, NIPAPAN	ARMSTRONG
SUWAN, MD, SAKDIDEJ	ARMSTRONG
SUWAN, SARUN	STUDENT
SUZUKI, MD, MARK M	ALLEGHENY
SVIGALS, MD, PAUL J	PHILADELPHIA
SWAAB, MD, RONALD L	PHILADELPHIA
SWACKHAMMER, MD, RANDY L	WESTMORELAND
SWAD, MD, SAMUEL J	WASHINGTON
SWAGLER, DO, CURTIS P	TIOGA
SWAIN, MD, STEPHEN S	SCHUYLKILL
SWALLOW, DO, WILLIAM B	UNION
SWAMI, MD, KUMAR	PHILADELPHIA
SWAMIDOSS, MD, STEPHENSON S	DAUPHIN
SWAMY, MD, MALLIKARJUNA S	ALLEGHENY
SWAN, MD, BARBARA E	ALLEGHENY
SWAN, MD, DAVID M	ALLEGHENY
SWANAY, RUTH S	STUDENT
SWANK, MD, MARK D	NORTHAMPTON
SWANSIGER, MD, ROBERT J	CAMBRIA
SWANSON, MD, JOEL W	ALLEGHENY
SWANSON, MD, LEE A	ALLEGHENY
SWANSON, MD, MICHAEL D	ALLEGHENY
SWANTEK, DO, LEO J	ERIE
SWARTZ, MD, EDWARD F	FRANKLIN
SWARTZ, MD, JOEL D	PHILADELPHIA
SWARTZ, MD, MARK A	FRANKLIN
SWARTZ, MD, STAN H	LYCOMING
SWARTZ, MD, WILLIAM M	ALLEGHENY
SWARUP, MONTE R	STUDENT
SWAYSER, DO, WILLIAM R	LEHIGH
SWEDARSKY, MD, ROBERT H	ALLEGHENY
SWEENEY, DO, DONALD J	TIOGA
SWEENEY, DO, THOMAS F	YORK
SWEER, MD, LEON W	CUMBERLAND
SWEGAL, MD, OTTO F	ALLEGHENY
SWEIGARD, MD, KEITH W	MONTGOMERY
SWEINBERG, MD, SHARON K	PHILADELPHIA
SWENSEN, MD, HAROLD E	ALLEGHENY
SWENSEN, MD, NANCY M	ALLEGHENY
SWENSEN, MD, WAYLENE W	DAUPHIN
SWENSON, MD, TODD M	ALLEGHENY
SWETERLITSCH, MD, LOUIS H	NORTHAMPTON
SWICK II, MD, J HOWARD	BEAVER
SWIDWA, MD, DENISE M	ALLEGHENY
SWIERCZEWSKI, MD, EDWARD V	WESTMORELAND
SWIFT, MD, FRANK L	LACKAWANNA
SWIFT, IAN R	STUDENT
SWIHART, MD, JEAN O	MONTGOMERY
SWISHER II, MD, CHARLES L	LACKAWANNA
SWITALA, MD, REGIS T	STUDENT
SWITZER, MD, GARY L	VENANGO
SYBING, MD, EUGENIO A	MERCER
SYBING, MD, MELITA M	MERCER
SYED, MD, TASNEEM A Z	WASHINGTON
SYKES, DO, LEROY I	DAUPHIN
SYKES JR, MD, NORMAN L	PHILADELPHIA
SYLVESTER, MD, ALFRED P	ALLEGHENY
SYLVESTER, MD, KARL G	PHILADELPHIA
SYLVESTRI, MD, GEORGE M	DAUPHIN
SYMES, MD, PHILIP H	ERIE
SYMS, MD, CHARLES A	PHILADELPHIA
SYROP, TAMA L	STUDENT
SYROPOULOS, MD, HEIDI J	CENTRE
SZABO, MD, EDWARD T	WESTMORELAND
SZABO, MD, EMIL R	HUNTINGDON
SZABO, MD, FERDINAND F	COLUMBIA
SZABO, MD, RUDOLPH G	COLUMBIA
SZAFRANSKI, MD, JOHN A	ALLEGHENY
SZAL, MD, JOSEPH J	PHILADELPHIA
SZALADOS, MD, JAMES E	PHILADELPHIA
SZARKO, MD, CAROL J	BERKS
SZARKO, MD, FRANK J	BERKS
SZARKO, MD, RICHARD J	LANCASTER
SZAYNA, MD, STANLEY	PHILADELPHIA
SZELES, MD, CHRISTOPHER B	PHILADELPHIA
SZOKE, MD, EDWARD E	ADAMS
SZOMSTEIN, MD, MARCOS	PHILADELPHIA
SZULBORSKI, MD, ROBERT G	LUZERNE
SZUSTAK, DO, JOSEPH J	LUZERNE
SZUTOWICZ, DO, MICHAEL P	LANCASTER
SZYDLOWSKI, MD, THADDEUS R	LEBANON
SZYMANSKI, MD, MARK B	MONTGOMERY

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TABACHNICK, MD, THEODORE M	ALLEGHENY
TABAS, MD, JANINE G	MONTGOMERY
TABB, MD, DAVID R	YORK
TABOR, MD, ELLEN K	ALLEGHENY
TABUENA, MD, AMELIA L	MONTGOMERY
TACHDJIAN, MD, VAHAKEN	PHILADELPHIA
TACHOVSKY, MD, THOMAS J	NORTHAMPTON
TADDONIO, MD, RICHARD B	BUCKS
TADDONIO, MD, WILLIAM S	CHESTER
TADJALLI, MD, HELEN E	YORK
TADLEY, DO, GERALD	PHILADELPHIA
TADROS, MD, MARY M	PHILADELPHIA
TAFFLIN, DO, DENNIS H	BUCKS
TAFTAF, MD, MOHAMMAD O	LAWRENCE
TAGALA, MD, PRAXIDIO H	CLEARFIELD
TAGGART, MD, GEORGE W	LUZERNE
TAGGART, MD, JAMES D	CUMBERLAND
TAGGART, MD, NINA M	LUZERNE
TAGGART, MD, TINA S	LUZERNE
TAGHIZADEH, MD, FIROOZ	FAYETTE
TAIT, MD, EDWIN C	MONTGOMERY
TAITELBAUM, MD, BEN	ALLEGHENY
TAKEDA, MD, MISAO	PHILADELPHIA
TALAGA, MD, RONALD N	WAYNE/PIKE
TALAMO, MD, ROBERT J	MONTGOMERY
TALANGBAYAN, MD, FRANCIS V	PHILADELPHIA
TALARICO, DO, JOSEPH F	ERIE
TALATI, MD, DINESHKUMAR C	LUZERNE
TALBERT, MD, MADONNA L	LANCASTER
TALBOT, MD, SHERYL F	PHILADELPHIA
TALBOTT, MD, JOHN B	ALLEGHENY
TALENTI, DONALD P	STUDENT
TALLERICO, MD, SAMUEL J	ALLEGHENY
TALLMAN, MD, EDWIN H	BERKS
TAM, MD, ISSAC T	CHESTER
TAMA, MD, LAWRENCE	BRADFORD
TAMAKI, MD, H TOM	MONTGOMERY
TAMBURRO, DO, VALERIE L	DELAWARE
TAN, MD, ANTHONY H	ALLEGHENY
TAN, MD, ANTONIUS H	LEHIGH
TAN, MD, BRADLEY A	ALLEGHENY
TAN, MD, CHRISTINA A	PHILADELPHIA
TAN, MD, EDWIN L	CAMBRIA
TAN, MD, ISABEL G	MERCER
TAN, MD, JACQUELINE G	BERKS
TAN, MD, LIAN K	CARBON
TAN, MD, MYRNA M	PHILADELPHIA
TAN, MD, SARTIKA M	PHILADELPHIA
TAN, MD, WILFREDO S	ERIE
TAN, MD, YOKE Y	DAUPHIN
TAN JR, MD, RAMON N	CAMBRIA
TANANIS, MD, LEONARD J	SCHUYLKILL
TANG, MD, GEOFFREY R	STUDENT
TANNEHILL, MD, NORMAN B	ALLEGHENY
TANNER, MD, LEONARD M	LEBANON
TANNING, MD, HOWARD M	ALLEGHENY
TANRIBILIR, MD, ABDUL K	COLUMBIA
TANTISIRA, MD, SOMPHONG	WESTMORELAND
TANTUM, MD, KERMIT R	DAUPHIN
TANUS, MD, TONNY	PHILADELPHIA
TANYOL, MD, HASIB	MONTGOMERY
TANZER, MD, PETER P	ALLEGHENY
TAPYRIK, MD, NICHOLAS	BEAVER
TARABISHI, MD, FARIDA NASR	ALLEGHENY
TARAS, MD, JOHN S	PHILADELPHIA
TARASZEWSKI, MD, ROBERT	MONTOUR
TARGUM, MD, STEVEN D	DELAWARE
TART JR, MD, BRASTON I	YORK
TARWATER, MD, DOYLE L	WASHINGTON
TASE, MD, DOUGLAS S	BERKS
TASMAN, MD, WILLIAM S	PHILADELPHIA
TASSAKIS, MD, TOM A	ALLEGHENY
TASSONE, ROSALIE F	STUDENT
TATARKO, MD, MICHAEL	CAMBRIA
TATE, MD, FREDERICK J	LEHIGH
TATEM III, MD, HENRY R	BUCKS
TATU, MD, WILLIAM F	MONROE
TATUM, MD, JAMES K	BEAVER
TAUBER, MD, JOSEPH B	ALLEGHENY
TAUBERG, MD, HERBERT R	ALLEGHENY
TAUBERG, MD, STUART G	ALLEGHENY
TAUBMAN, MD, RANDALL M	DAUPHIN
TAUS, DO, JOHN K	LEHIGH
TAUSCH, MD, GILBERT S	MONTGOMERY
TAVANA, MD, MANOUCHER	ERIE
TAVANI, DO, DEEBEANNE M	PHILADELPHIA
TAVARES, MD, JOAO O	ERIE
TAVARES, MD, JOSEPH F	NORTHMBRLAND
TAVARIA, MD, SOLI	SCHUYLKILL
TAX, MD, RICHARD L	BUCKS
TAXIN, MD, RICHARD N	DELAWARE
TAYLOR, MD, BRADLEY S	ALLEGHENY
TAYLOR, MD, BRIAN T	FAYETTE
TAYLOR, MD, CAROLYN L	BUCKS
TAYLOR, MD, DEBRA D	CUMBERLAND
TAYLOR, MD, JAMES A	MONROE
TAYLOR, MD, JAMES E	PHILADELPHIA
TAYLOR, MD, MARCIA R	MONTGOMERY
TAYLOR, MD, MARK A	BLAIR
TAYLOR, MD, MEGAN B	MONTGOMERY
TAYLOR, MD, PHILIP C	PHILADELPHIA
TAYLOR, MD, SHARON L	ALLEGHENY
TAYLOR, MD, SUSAN C	PHILADELPHIA
TAYLOR, MD, THOMAS J	FRANKLIN
TAYLOR III, MD, JAMES S	DAUPHIN
TAYLOR-TYREE, MD, GILL M	ADAMS
TCHONG, MD, KUO-LIANG	DELAWARE
TEANO, MD, DAN A	DELAWARE
TECCE, MD, MARC A	PHILADELPHIA
TEDESCO, DO, J MICHAEL	LUZERNE
TEDESCO, DO, JOHN A	ERIE
TEE, MD, STEVEN T	ALLEGHENY
TEEHAN, MD, BRENDAN P	MONTGOMERY
TEEPLE JR, MD, EDWARD	ALLEGHENY
TEET, MD, DANIEL A	WESTMORELAND
TEETER, MD, JAMES H	FRANKLIN
TEGELER, MD, JAMES A	YORK
TEGTMEIER, MD, TODD A	LYCOMING
TEGZES JR, MD, GEORGE	ALLEGHENY
TEH, MD, PEK C	LAWRENCE
TEICH, MD, STEPHEN M	MONTGOMERY
TEICHMAN, MD, FRED	UNION
TEITELBAUM, MD, CARL	LUZERNE
TEJPAR, MD, MOHAMED K	LAWRENCE
TEMELES, MD, LAWRENCE	PHILADELPHIA
TEMELES, MD, ROY S	ALLEGHENY
TEMIZER, MD, DOGAN H	MONTGOMERY
TEMPLE, MD, ANTHONY R	CHESTER
TEMPLETON, MD, BRYCE	PHILADELPHIA
TEMPLETON, JAMES B	STUDENT
TEMPLETON, MD, JOSEPHINE J	PHILADELPHIA
TEMPLETON III, MD, JOHN Y	PHILADELPHIA

TEMPLETON JR, MD, JOHN M	PHILADELPHIA
TENAGLIA, MD, NICHOLAS C	MONTGOMERY
TENDLER, MD, STEVEN W	MONTGOMERY
TENEDIOS, MD, GEORGE	MONTOUR
TENENOUSER, MD, BARRY	ALLEGHENY
TENER, TRILBY J	STUDENT
TENICELA, MD, RUBEN	ALLEGHENY
TENSUAN JR, MD, LEONARDO S	SOMERSET
TEODORO, MD, JOSE V	CAMBRIA
TEPLICK, MD, J GEORGE	PHILADELPHIA
TEPLIS, MD, ALAN C	DAUPHIN
TEPPER, MD, MAURICE C	PHILADELPHIA
TEPPER, MD, RICHARD L	PHILADELPHIA
TEREDESAI, MD, PRADIP R	ALLEGHENY
TERHAAR, DO, PETER J	COLUMBIA
TERMINI, MD, JOSEPH T	LEHIGH
TERNER, MD, IRWIN S	ALLEGHENY
TERNES, MD, ROBERT J	FRANKLIN
TERRY, MD, CHARLES M	STUDENT
TERRY, MD, JOHN M	TIOGA
TERSHAKOVEC, MD, ANDREW M	PHILADELPHIA
TERZIAN, MD, ALLEN E	DELAWARE
TESSARO, MD, ANNE N	ALLEGHENY
TESSLER, MD, A ROBERT	PHILADELPHIA
TESTA, MD, JOSEPH A	WESTMORELAND
TESTA, DO, MARK A	PHILADELPHIA
TESTER, MD, WILLIAM J	PHILADELPHIA
TETRICK, MD, ELBERT L	ALLEGHENY
TEUFEL, MD, SEVERIN	MONTGOMERY
TEY, MD, PETER H	CARBON
THAETE, MD, F LELAND	ALLEGHENY
THAKARAR, MD, PUSHPA	CHESTER
THAKER, MD, UPENDRA N	ELK/CAMERON
THAL, MD, IRA M	CHESTER
THALER, MD, ERICA R	PHILADELPHIA
THALLURI, MD, RANGA R	ALLEGHENY
THAMES, DO, RICHARD	JEFFERSON
THANE, MD, T TOE	FRANKLIN
THANKI, MD, ASHOKKUMAR S	BUCKS
THASE, MD, MICHAEL E	ALLEGHENY
THATCHER, MD, JEFFREY D	BUCKS
THAVENDRARBAH, MD, VASANTHY	NORTHAMPTON
THEAKSTON, MD, ROBERT W	WASHINGTON
THEIN, MD, WIN	LEHIGH
THEIS, MD, STEVEN W	ALLEGHENY
THEL JR, MD, HENRY C	BEAVER
THEMAN, MD, TERRILL E	NORTHAMPTON
THEODORAN, DO, CHRIS G	LANCASTER
THETGYI, MD, KATHERINE	PHILADELPHIA
THEURKAUF JR, MD, EDWARD A	CHESTER
THIELE, MD, BRIAN L	DAUPHIN
THIMMIAH, MD, RAMESH	ALLEGHENY
THODER, MD, JOSEPH J	PHILADELPHIA
THOMAS, MD, ALEX T	LEHIGH
THOMAS, MD, ANN-MARIE S	PHILADELPHIA
THOMAS, MD, BRUCE L	HUNTINGDON
THOMAS, MD, CARMEN C	PHILADELPHIA
THOMAS, DO, CHARLES E	YORK
THOMAS, MD, CHESTER G	DAUPHIN
THOMAS, MD, CHRISTINE R	ALLEGHENY
THOMAS, MD, CHRISTOPHER W	CRAWFORD
THOMAS, DO, DAVID A	DELAWARE
THOMAS, MD, DAVID E	ALLEGHENY
THOMAS, MD, DAVID S	LACKAWANNA
THOMAS, MD, EVAN J	PHILADELPHIA
THOMAS, DO, GARY S	CAMBRIA
THOMAS, MD, GEORGE P	CARBON
THOMAS, MD, HAROLD D	WASHINGTON
THOMAS, MD, HARRY L	PHILADELPHIA
THOMAS, MD, HENRY W	ALLEGHENY
THOMAS, MD, HOLLY J	PHILADELPHIA
THOMAS, MD, JAMES H	WESTMORELAND
THOMAS, MD, JOHN J	PHILADELPHIA
THOMAS, MD, JOHN W	ALLEGHENY
THOMAS, MD, JOSEPH M	ERIE
THOMAS, MD, L MARTHA ANN	YORK
THOMAS, MD, LISA C	ALLEGHENY
THOMAS, MD, LYNDA T	PHILADELPHIA
THOMAS, MD, NATHAN O	SOMERSET
THOMAS, MD, ROBERT D	ALLEGHENY
THOMAS, MD, RONALD L	ALLEGHENY
THOMAS, MD, STEPHEN J	ERIE
THOMAS, MD, STEPHEN M	ALLEGHENY
THOMAS, MD, TERRENCE J	SOMERSET
THOMAS, MD, VICTOR J	ALLEGHENY
THOMAS, MD, WILLIAM E	MERCER
THOMAS JR, MD, DAVID W	CLINTON
THOMAS JR, MD, HOWARD P	BUCKS
THOMAS JR, MD, JAMES A	DELAWARE
THOMAS JR, MD, JAMES J	ERIE
THOMAS JR, MD, JOHN W	PHILADELPHIA
THOME, DO, DONALD H	MIFFLIN/JUNIATA
THOMPSON, MD, BRADFORD R	BEAVER
THOMPSON, MD, C FRED	NORTHAMPTON
THOMPSON, MD, CAREN L	PHILADELPHIA
THOMPSON, MD, CARSON J	LACKAWANNA
THOMPSON, MD, DAN R	ALLEGHENY
THOMPSON, MD, DAVID I	CUMBERLAND
THOMPSON, MD, GREGORY M	CHESTER
THOMPSON, MD, HERBERT	ALLEGHENY
THOMPSON, HOLLY J	STUDENT
THOMPSON, MD, JAMES W	MONTGOMERY
THOMPSON, DO, JEFFREY N	ALLEGHENY
THOMPSON, MD, JOHN W	JEFFERSON
THOMPSON, MD, LINDA G	BEAVER
THOMPSON, MD, MARK E	ALLEGHENY
THOMPSON, MD, PETER J	VENANGO
THOMPSON, MD, ROBERT J	LEHIGH
THOMPSON, MD, ROBERT L	CUMBERLAND
THOMPSON, MD, ROBERT L	ALLEGHENY
THOMPSON, TODD P	STUDENT
THOMPSON, MD, WILLIAM W	ELK/CAMERON
THOMPSON II, MD, TROY L	PHILADELPHIA
THONET, MD, MARCEL A	PHILADELPHIA
THORNSLEY, MD, SUSAN L	DAUPHIN
THORNTON, MD, JOSEPH K	FRANKLIN
THORNTON III, MD, JAMES J	DELAWARE
THORP, MD, T RAMSEY	PHILADELPHIA
THORSEN JR, MD, WILLIAM B	YORK
THORYK, MD, DAVID T	LYCOMING
THOYER, ERINN	STUDENT
THURMAN, MD, JOHN N	DELAWARE
THYAGARAJAN, MD, ANANTHAK	ALLEGHENY
TIANGCO, MD, BEATRICE J	ALLEGHENY
TIBBELS JR, MD, EWING W	BUCKS
TIBBENS, MD, GEORGE F	WASHINGTON
TIBBITTS, MD, JAMES A	LEBANON
TIBERIO, MD, RICHARD A	FAYETTE
TIBURCIO JR, MD, ALBINO F	BUTLER
TICK, MD, ROBERT C	BLAIR
TICZON, MD, ANDRES R	ALLEGHENY
TIECHE, MD, STEVEN C	MCKEAN
TIEDEKEN III, MD, JOHN J	STUDENT
TIEFF, DO, MICHAEL W	MONROE
TIETBOHL, MD, RALPH H	BERKS
TIETJEN, MD, GEORGE W	WAYNE/PIKE
TIFFANY, MD, JOHN R	NORTHAMPTON
TIGER, MD, MELVYN E	PHILADELPHIA
TIGNOR, MD, RICHARD F	LYCOMING
TILLIM, MD, STEPHEN L	LYCOMING
TILTON, DO, BRUCE R	CHESTER
TILVA, MD, PRAFUL K	NORTHMBRLAND
TIMEK, MD, PATRICIA A	CAMBRIA
TIMENS, MD, LAWRENCE J	CAMBRIA
TIMKO, MD, JOHN V	PHILADELPHIA
TIMMINS III, MD, PATRICK F	ALLEGHENY
TIMOTHY, MD, SHEILA H	FAYETTE
TINDALL, MD, HERBERT L	LANCASTER
TINDALL, MD, JANICE C	LANCASTER
TING, MD, ROSALIND Y	PHILADELPHIA
TINIANOW, MD, LLOYD N	LEHIGH
TINKLEPAUGH, MD, CAROLE N	MONTGOMERY
TINNEY JR, MD, WILLIAM S	LANCASTER
TINSLEY, MD, WENDY W	BUCKS
TINTNER, DO, SUZANNE G	DAUPHIN
TIONGSON, MD, ELEANOR S	DELAWARE
TIONGSON JR, MD, JOSE G	DELAWARE
TIPPERMAN, MD, RICHARD	PHILADELPHIA
TIPPET, MD, PAUL D	ALLEGHENY
TIPPING, MD, JAMES S	ALLEGHENY
TIPTON, MD, RAYMOND L	VENANGO
TIRUCHELVAM, MD, VASUDEVAN	YORK
TISHERMAN, MD, SAMUEL A	ALLEGHENY
TISHERMAN, MD, SAMUEL E	ALLEGHENY
TITCHWORTH, MD, ROY L	ALLEGHENY
TITI, MD, MARK J	LANCASTER
TITMAN, MD, WILLIAM E	COLUMBIA
TIU, MD, GRISELDA E	MONTGOMERY
TIU, MD, JOHN L	LEHIGH
TIVAKARAN, MD, SANJEEVI C	DAUPHIN
TKATCH, MD, LISA S	DAUPHIN
TOAL, MD, THOMAS M	VENANGO
TOBIA, MD, ENIO W	DELAWARE
TOBIAS, MD, GORDON L	MONTGOMERY
TOBIAS, MD, RICHARD B	LYCOMING
TOBIASZ, MD, CHRISTOPHER	LYCOMING
TODARO, MD, SAMUEL R	LACKAWANNA
TODHUNTER, MD, WILLIAM J	LYCOMING
TODOR, MIRCEA C	STUDENT
TODOROVSKA, MD, ZAGORKA	PHILADELPHIA
TOFF, DO, KENNETH J	LEHIGH
TOKARS, MD, ROGER P	ALLEGHENY
TOLAN, MD, JEFFREY R	DAUPHIN
TOLAND, MD, JOSEPH C	PHILADELPHIA
TOLAND, MD, JOSEPH J	PHILADELPHIA
TOLAT, MD, PRATIMA R	PHILADELPHIA
TOLEDANO, MD, CONRADO P	ERIE
TOLEDO, MD, FRANCISCO L	PHILADELPHIA
TOLENTINO, MD, JULIAN C	BUTLER
TOLENTINO, MD, PABLITO L	BUCKS
TOLIS, MD, BASILE D	BLAIR
TOLLERUD, MD, DAVID J	ALLEGHENY
TOLLETT, MD, CHARLES A	PHILADELPHIA
TOLMAN, MD, LEON M	ARMSTRONG
TOM, MD, CAROL M	MONTGOMERY
TOM, MD, LAWRENCE WC	PHILADELPHIA
TOM, MD, TODD N	CLARION
TOMA, MD, MICHAEL J	PHILADELPHIA
TOMACK, MD, LAWRENCE S	LYCOMING
TOMARELLI, MD, RAYMOND C	ALLEGHENY
TOMASELLO, MD, DONALD N	PHILADELPHIA
TOMASI, MD, SAMUEL J	BEAVER
TOMAZIC, DO, DAVID R	LACKAWANNA
TOME, MD, JULIA A	ALLEGHENY
TOMEDI, MD, JOHN R	LUZERNE
TOMEO, MD, MICHAEL	MONTGOMERY
TOMEZSKO, MD, JANET E	LEHIGH
TOMHAVE, MD, ROBERT H	CAMBRIA
TOMIE, MD, HISASHI	ALLEGHENY
TOMITA, ROBIN Y	STUDENT
TOMKO, MD, LINDA P	PHILADELPHIA
TOMLEY, MD, JOHN E	ALLEGHENY
TOMLIN, MD, JOSEPH G	SCHUYLKILL
TOMLINSON, MD, JOHN W	DELAWARE
TOMLINSON, MD, JOHN W	BUCKS
TONDREAU, MD, RODERICK L	PHILADELPHIA
TONEY, MD, DAVID M	WESTMORELAND
TONEY, MD, MELINDA Q	NORTHAMPTON
TONG, MD, DER-LONG	ALLEGHENY
TONKONOW, MD, BARRY L	BUCKS
TONNIES, MD, DAVID A	ALLEGHENY
TONSEY, MD, HABIB	PHILADELPHIA
TOOR, MD, SHAISTA N	ALLEGHENY
TOORKEY, MD, BEHNAZ C	PHILADELPHIA
TOOZE, MD, FRANK M	ERIE
TOPAL, MD, JEFFREY E	PHILADELPHIA
TOPERZER, MD, BETTY C	ERIE
TOPOLSKY, MD, DAVID LANE	PHILADELPHIA
TOPORCER, MD, MARY B	BUCKS
TORAYA, CINDY E	STUDENT
TORCHIA, MD, JOSEPH A	DAUPHIN
TORCHIA, MD, MARY J	ALLEGHENY
TOREN, MD, PETER C	MONTGOMERY
TORET, MD, MICHEL P	WESTMORELAND
TORI, MD, JOSEPH N	DELAWARE
TORIO, MD, REYNALDO M	WESTMORELAND
TORNETTA, MD, FRANK J	MONTGOMERY
TOROK, MD, FRANK S	WASHINGTON
TORONY-OKUN, MD, JEANNE A	LUZERNE
TORP, MD, LISA K	DAUPHIN
TORPEY JR, MD, DAVID J	ALLEGHENY
TORPIE, MD, BARBARA A P	PHILADELPHIA
TORRENCE, MD, MICHAEL B	DELAWARE
TORRES, MD, CARLOS P	ALLEGHENY
TORRES, MD, FLORA M	BEDFORD
TORRES, MD, JULIO E	NORTHAMPTON
TORRES, MD, MARGARITA	PHILADELPHIA
TORRES, MD, ROBIN G	BEDFORD
TORRES, MD, VICTOR L	PHILADELPHIA
TORRETTI, MD, DENNIS	MONTOUR
TORREY, MD, EDWIN H	YORK
TOSHNIWAL, MD, PRADIP K	NORTHAMPTON
TOSHNIWAL, MD, RENU	NORTHAMPTON
TOSO, MD, GIANFRANCO F	BERKS
TOTINO, MD, JOSEPH A	DELAWARE
TOUCH, MD, SUZANNE M	PHILADELPHIA
TOUSI, MD, ABBAS H	BEDFORD
TOVEY, MD, JAMES E	MONROE
TOWERS, MD, ADELE L	ALLEGHENY
TOWERS, MD, JEFFREY D	ALLEGHENY
TOWNEND, MD, STEPHEN C	CHESTER
TOWNSEND, MD, JAY A	CUMBERLAND
TOWNSEND, MD, MARK E	ERIE
TOWNSLEY, MD, MALCOLM C	PHILADELPHIA
TRABULSI, MD, L RICHARD	DELAWARE
TRACHTENBERG, MD, LEE A	ALLEGHENY
TRACHTENBERG, MD, WILLIAM M	LEHIGH
TRACHTMAN, MD, WILLIAM M	MERCER
TRACY, MD, GERALD P	LACKAWANNA
TRAGER, MD, JONATHAN D K	ALLEGHENY
TRAGESER, MD, TIMOTHY C	ERIE
TRAIMAN, MD, RICHARD G	CHESTER
TRAIN, MD, HENRY D	DAUPHIN
TRAINER, MD, PAUL J	ALLEGHENY
TRAJTENBERG, MD, GEORGE A	CHESTER
TRAN, CECILIA H	STUDENT
TRAN, MD, NEIL N	MONTGOMERY
TRAN, TIMOTHY C	STUDENT
TRAN, MD, TRAN N	CUMBERLAND
TRANCHITELLA, MD, VINCENT J	YORK
TRANOVICH, MD, MARK	FAYETTE
TRANOVICH, MD, MICHAEL A	ALLEGHENY
TRAUM, MD, RONALD E	PHILADELPHIA
TRAUPMAN, MD, ARNOLD F	NORTHAMPTON
TRAUTLEIN, MD, JOSEPH J	DAUPHIN
TRAVERS, MD, DANIEL J	WESTMORELAND
TRAVISANO, MD, FRANK J	DAUPHIN
TRAY, MD, BRIAN P	FRANKLIN
TRECHA, MD, GREGORY T	BEAVER
TREDENNICK, MD, CHARLES N	BUTLER
TREGER, MD, ALBERT	ALLEGHENY
TRELLA, MD, JENNIFER M	DAUPHIN
TRELLIS, MD, DAN R	ALLEGHENY
TRELLIS, MD, EMIL S	ALLEGHENY
TREMBLAY, MD, ERNEST A	DELAWARE
TREMOR, MD, ISNARDO E	LEHIGH
TRENTON, DO, WALTER D	SOMERSET
TRETTER, DO, JAMES F	CAMBRIA
TRETTER, DO, MARGARET S	LEHIGH
TREVASKIS, MD, ALLAN E	LEHIGH
TREVI, EXEC DIR, JOHN	PHILADELPHIA
TREVLYN, MD, DEAN W	DELAWARE
TREVORROW, MD, THOMAS C	INDIANA
TREXLER, MD, ETHAN L	BERKS
TREZZA, MD, SCOTT A	CHESTER
TRIANA COOPER, MD, LISETTE	PHILADELPHIA
TRIANO, MD, GENE J	DAUPHIN
TRIANTAFYLLOU, MD, STEVEN J	YORK
TRIBBLE, MD, JANA K	NORTHAMPTON
TRIBIT JR, MD, CHARLES B	PHILADELPHIA
TRICHTINGER, MD, MARTIN D	MONTGOMERY
TRIESTER, MD, ARTHUR N	PHILADELPHIA
TRIMMER JR, MD, JOHN H	YORK
TRIMPI, MD, HOWARD D	LEHIGH
TRINH, MD, CHUONG V	MONTGOMERY
TRINH, MD, PHUONG N	PHILADELPHIA
TRINIDAD, MD, TITO B	CLEARFIELD
TRIOLO, MD, JOSEPH	DELAWARE
TRIPATHI, MD, SANJAY P	BRADFORD
TRIPI, MD, JOSEPH E	ADAMS
TRIPOLI, MD, CHARLES J	WASHINGTON
TRIPOLI, MD, LOUIS C	WASHINGTON
TRIPPITELLI, CAROL L	STUDENT
TRISAL, MD, VIJAY K	ALLEGHENY
TRITSCHLER, MD, JOSEPH P	BEAVER
TRIULZI, MD, DARRELL J	ALLEGHENY
TRIVEDI, MD, GOPALKRISHNA M	MIFFLIN/JUNIATA
TRIVUS, MD, ROBERT H	ALLEGHENY
TROCKI-VIDELL, DO, CYLA	PHILADELPHIA
TROIANOS, MD, CHRISTOPHER A	ALLEGHENY
TROLLINGER, MD, ROBERT J	PHILADELPHIA
TROMBETTA, MD, MARK G	ALLEGHENY
TROMPETER, MD, JOSEPH I	ALLEGHENY
TRONCALE, MD, JOSEPH A	BERKS
TRONCELLITI, MD, A WAYNE	MONTGOMERY
TRONCELLITI, MD, ALFRED E	MONTGOMERY
TRONCELLITI, MD, MARIO V	PHILADELPHIA
TRONETTI, DO, MICHAEL J	ERIE
TRONETTI, DO, PAMELA S	ERIE
TROPEA, DO, JOSEPH N	PHILADELPHIA
TROSTLE, MD, DAVID C	LEBANON
TROSTLE, MD, DOUGLAS R	LEHIGH
TROTT, MD, MILLARD C	ALLEGHENY
TROTTMAN, MD, JENNIFER E	MONTGOMERY
TROTZKY, MD, MARGRET S	DELAWARE
TROUT, MD, JOHN A	WESTMORELAND
TROXEL, MD, RICHARD S	LEHIGH
TROYAN, MD, BARRY E	INDIANA
TRUEX JR, MD, RAYMOND C	BERKS
TRUITT, MD, GEORGE W	CHESTER
TRUITT JR, MD, R MARSHALL	PHILADELPHIA
TRUJILLO, MD, RENE	WYOMING
TRUMP, MD, BRYCE E	DAUPHIN
TRUONG, MD, NICHOLAS H	PHILADELPHIA
TRUSKY, MD, JEANETTE I	CENTRE
TRYBUS JR, MD, ADAM G	BLAIR
TRYON, BRIAN C	STUDENT
TSAI, DAVID	STUDENT
TSAI, MD, EDWARD M	INDIANA
TSAI, GEORGE T	STUDENT
TSAI, MD, JER-YUAN	GREENE
TSAI, MD, MING C	BLAIR
TSAI, MD, YU J	MONTGOMERY
TSAMBASSIS, MD, NICHOLAS A	WASHINGTON
TSAROUHAS, MD, NICHOLAS	PHILADELPHIA
TSE, MD, ROSE L	PHILADELPHIA
TSENG, MD, CHUN-MING	PHILADELPHIA
TSENG, MD, FRANCIS H	ERIE
TSENG, ROBERT R	STUDENT
TSOUTSOPLIDES, MD, GEORGE C	LUZERNE
TSU, MD, JACQUELYNN L	MONTGOMERY
TUAN, MD, BAO-KUEN	PHILADELPHIA
TUCHINDA, MD, JALIT	ALLEGHENY
TUCKER, MD, JAMES N	ALLEGHENY
TUCKER, MD, JEANIANNE	PHILADELPHIA
TUCKER, MD, SAMUEL H	PHILADELPHIA
TUCKER, MD, THOMAS W	CHESTER
TUFFAHA, MD, HANI J	LYCOMING
TUFFIASH, MD, WILLIAM A	LEHIGH
TUKANOWICZ, MD, STANISLAW A	CAMBRIA
TULCHINSKY, MD, MARK	DAUPHIN
TULISZEWSKI, MD, ROBERT M	ADAMS
TULL, MD, JOHN W	YORK
TULLAI, MD, JOHN	DELAWARE
TULLIUS, MD, CHARLES D	FAYETTE
TULLOCK, MD, WILLIAM C	ALLEGHENY
TULLY, MD, VINCENT J	WAYNE/PIKE
TULSKY, MD, EMANUEL G	PHILADELPHIA
TUMAIAN, MD, ARAM	DELAWARE
TUMEN, MD, HENRY J	PHILADELPHIA
TUNICK, MD, STEPHEN E	BEAVER
TUNNESSEN JR, MD, WALTER W	PHILADELPHIA
TUPCHONG, MD, LESLIE	DELAWARE
TURBESSI, MD, ALBERT J	WARREN
TURBESSI, MD, EILEEN M	WESTMORELAND
TURCAN, DO, ELAINE C	LUZERNE
TURCHETTI, MD, EUGENE A	LACKAWANNA
TURCO, MD, MARK A	PHILADELPHIA
TUREL JR, MD, ANTHONY P	MONTOUR
TURISSINI, MD, THOMAS J	LUZERNE
TURK, CARL R	STUDENT
TURKEWITZ, MD, DAVID	MONTOUR
TURNAMIAN, MD, RICHARD J	LUZERNE
TURNBULL, MD, ROBERTO E	INDIANA
TURNER, MD, CLINTON A	PHILADELPHIA
TURNER, DO, CRAIG F	ALLEGHENY
TURNER, MD, JOSEPH	ALLEGHENY
TURNER, MD, MORRIS E	ALLEGHENY
TURNER, MD, OLIVER E	ALLEGHENY
TURNER III, MD, JOHN F	UNION
TURNER JR, MD, J ELLIS	DELAWARE
TURNQUIST, PAUL E	STUDENT
TUROCK, MD, MICHAEL J	LACKAWANNA
TUROCY, MD, JOHN F	ALLEGHENY
TURSKY, MD, ROSEMARIE J	DAUPHIN
TURTZ, MD, ALAN R	PHILADELPHIA
TURTZO, MD, DOUGLAS F	NORTHAMPTON
TURULA, MD, JON B	LANCASTER
TUSHIM, MD, JOSEPH N	BLAIR
TUTTLE, MD, ALFRED	ALLEGHENY
TUTTLE, MD, WILLIAM B	ALLEGHENY
TWAL, MD, SHAFIC Y	INDIANA
TWER, MD, ALAN J	MONTGOMERY
TWERSKI, MD, ABRAHAM J	ALLEGHENY
TWIGGAR II, MD, EDWARD V	NORTHMBRLAND
TYEHIMBA, MD, ARTHUR	FAYETTE
TYLER, MD, JOHN R	LANCASTER
TYLKA-HOFFMAN, MD, ELEANOR M	ALLEGHENY
TYMA, MD, CATHY S	ALLEGHENY
TYMA, MD, THOMAS A	ALLEGHENY
TYMOCZKO, MD, ROBERT G	WESTMORELAND
TYMON, MD, TIMOTHY P	LANCASTER

TYNDALL, MD, CHRISTINE S	ALLEGHENY
TYNDALL, MD, JAMES A	DAUPHIN
TYSON, MD, R ROBERT	PHILADELPHIA
TZARNAS, MD, CHRIS D	PHILADELPHIA

U

UBER, MD, THOMAS R	LAWRENCE
UBERTI, MD, ANTHONY F	WASHINGTON
UBERTI, DO, FREDERICK G	MERCER
UDARBE, MD, GUILLERMO G	ELK/CAMERON
UDEKWU, MD, CATHERINE N	ALLEGHENY
UDELL, MD, LOUIS	PHILADELPHIA
UDOSHI, MD, MALLAPA B	LUZERNE
UFBERG, MD, MICHAEL H	LEHIGH
UFFNER, MD, JULIA M	PHILADELPHIA
UHLMAN, MD, ERIC J	CHESTER
UHLMAN, MD, RICHARD C	CHESTER
UJEVICH, MD, M MARK	ALLEGHENY
UKWU, MD, HENRIETTA N	PHILADELPHIA
ULASEWICZ, MD, CATHERINE C	BUCKS
ULASEWICZ, MD, JOSEPH T	MONTGOMERY
ULBRECHT, MD, JAN S	CENTRE
ULICHNEY, ANDREW B	STUDENT
ULICNY, MD, THOMAS L	ALLEGHENY
ULITSKY, MD, MARK I	BUCKS
ULIZIO, MD, ANTHONY R	ALLEGHENY
ULMER, LORIE R	STUDENT
ULRICH, MD, JACK M	ALLEGHENY
ULRICH, MD, SAMUEL D	DAUPHIN
ULTMANN, MD, MICHELLE C	ALLEGHENY
UMALI, MD, IDONA C	LUZERNE
UMAR, MD, KENAN	MONTGOMERY
UMEH, MD, ONUORAH I	PHILADELPHIA
UNAL, MD, ABDURRAHMAN	DAUPHIN
UNDERHILL, MD, WILLIAM L	ERIE
UNDERWOOD, MD, MARA Z	MONTGOMERY
UNDERWOOD, MD, SUSAN K	MONTGOMERY
UNGER, MD, ANDREW	NORTHAMPTON
UNGER, DO, DONALD	ERIE
UNGER, MD, MICHAEL	MONTGOMERY
UNGKANONT, MD, ARTIT	ALLEGHENY
UNWALA, MD, ASHFAQUE A	PHILADELPHIA
UNWIN, MD, WILLIAM M	YORK
UPDEGRAFF, MD, WILLIAM C	ALLEGHENY
UPDEGROVE, MD, JOHN H	NORTHAMPTON
UPDEGROVE, MD, ROBERT A	LYCOMING
UPDIKE JR, MD, FURMAN T	YORK
URAM, MD, HERBERT	ALLEGHENY
URBACH, MD, FREDERICK	MONTGOMERY
URBAN, MD, CLIFFORD H	CHESTER
URBAN, MD, DONALD G	CUMBERLAND
URBAN, MD, MELANIE A	PHILADELPHIA
URBAN, MD, RENA L	ALLEGHENY
URBAN, MD, RICHARD S	ALLEGHENY
URBAN, MD, ROBERT R	WESTMORELAND
URBAN JR, MD, FRANK E	ALLEGHENY
URBANO, MD, ANTHONY M	NORTHAMPTON
URBANO, MD, FRANK L	PHILADELPHIA
URI, MD, ANTONIA K	PHILADELPHIA
URICCHIO, MD, FRANCIS J	PHILADELPHIA
URICCHIO, MD, JOSEPH F	PHILADELPHIA
UROSKIE, JONATHAN A	STUDENT
UROSKIE, MD, THEODORE W	LACKAWANNA
UROSKIE JR, THEODORE W	STUDENT
URQUHART, MD, MARION LENA	PHILADELPHIA
URREA, MD, OSCAR	WASHINGTON
URSINO, MD, GREGORY	ALLEGHENY
USELMAN, MD, JAMES H	ALLEGHENY
USHINSKI, MD, STANLEY C	LUZERNE
UTBERG, MD, JOHN R	ALLEGHENY
UTSINGER, MD, PETER D	MONTGOMERY
UTZ, JEFFREY P	STUDENT
UY, MD, HENRY T	WASHINGTON
UY, MD, NONITA T	ALLEGHENY

V

VACCARO, MD, V MICHAEL	PHILADELPHIA
VACCARO III, MD, ALEXANDER R	PHILADELPHIA
VACHARAT, MD, NIBONDH	PHILADELPHIA
VACHHANI, MD, MANSUKHLAL P	NORTHAMPTON
VACHHANI, MD, VINUBHAI M	LUZERNE
VACHRANUKUNKIET, MD, THEERASAKID	MONTGOMERY
VAFEAS, MD, JOYCE A	LANCASTER
VAGANOS, MD, NICHOLAS A	CHESTER
VAGANOS, MD, STEVE A	MONTGOMERY
VAGLEY, MD, RICHARD T	ALLEGHENY
VAHANVATY, MD, RAMLAH M	MONROE
VAHEDI, MD, HOUSHANG M	MONTGOMERY
VAIDYA, MD, SHAILENDRA	PHILADELPHIA
VAIL, MD, SYDNEY J	MONTGOMERY
VAKHARIA, MD, PRATIBHA V	MIFFLIN/JUNIATA
VAKHARIA, MD, VIJAY H	MIFFLIN/JUNIATA
VAKIL, MD, HASSAN C	DELAWARE
VALCARCEL, MD, SOFRONIO J	ALLEGHENY
VALDES, MD, CONRADO A	MCKEAN
VALDIVIA, MD, DUILIO E	MIFFLIN/JUNIATA
VALENA, MD, ELENA V	MERCER
VALENCIA, MD, CELEDONIO C	BERKS
VALENTEEN, MD, J WALTER	DELAWARE
VALENTINE, MD, JEROME D	PHILADELPHIA
VALENTINO, DO, STEVEN J	MONTGOMERY
VALERIANO, MD, JAMES P	ALLEGHENY
VALIGORSKY, MD, PAUL J	ELK/CAMERON
VALKO, MD, ANNEMARIE S	ALLEGHENY
VALKO, MD, GEORGE P	PHILADELPHIA
VALLABH, MD, SAGAR V	MERCER
VALLE, MD, EDGAR O	DELAWARE
VALLEJO, MD, JOSE A	PHILADELPHIA
VALLEJO, MD, MANUEL C	WASHINGTON
VALLIAPPAN, MD, SWAMINATHAN	ALLEGHENY
VALLOROSI, CHRISTOPHER J	STUDENT
VALLOW, MD, MORTON J	PHILADELPHIA
VALVERDE, MD, MARIO F	LACKAWANNA
VAN ANTWERP, MD, MARK A	POTTER
VAN BLARGAN, DO, MARK S	LUZERNE
VAN DE BEEK, MD, M LOUIS	PHILADELPHIA
VAN DECKER, MD, WILLIAM A	PHILADELPHIA
VAN DUZER, SCOTT T	STUDENT
VAN HOVE, MD, SHAWN P	ERIE
VAN NESS, SUZANNE M	STUDENT
VAN TIL, ETHAN S	STUDENT
VAN VOORHEES, MD, ABBY S	MONTGOMERY
VANBUSKIRK, MD, CHARLES	YORK
VANDAMIA, MD, DONALD N	ERIE
VANDER, MD, JAMES F	PHILADELPHIA
VANDERBEEK, MD, RICHARD R	BUCKS
VANDERLIN, MD, ROBERT L	LYCOMING
VANDERPOOL, MD, RAMON A	BUCKS
VANDERVEER, MD, JOSEPH B	MONTGOMERY
VANDERVEER, MD, LINDSLEY D	NORTHAMPTON
VANDYK, MD, KLAAS	WESTMORELAND
VANETT, MD, BRUCE B	DELAWARE
VANGAALEN, MD, ADRIAAN J	NORTHAMPTON
VANGIESEN, MD, PETER J	YORK
VANGORE, MD, SURYA K	PHILADELPHIA
VANKIRK JR, MD, JOHN S	ALLEGHENY
VANNATTA, MD, FRED C	WAYNE/PIKE
VANRIPER, MD, DANIEL F	PHILADELPHIA
VANSANT, MD, ALAN E	YORK
VANSCOTT, MD, EUGENE J	MONTGOMERY
VANSTRIEN, MD, ADRIAN R	WASHINGTON
VANVORIS, MD, LEE P	ERIE
VANWYK, MD, RITA E	YORK
VARACALLO, MD, ALBERT L	JEFFERSON
VARADA, MD, ANNAPOORNA	PHILADELPHIA
VARADA, MD, K P BABU	MONTGOMERY
VARANELLI, MICHAEL J	STUDENT
VARANO, MD, LOTTIE A	LANCASTER
VARAT, MD, MURRAY A	ALLEGHENY
VARAV, KALLE	STUDENT
VARDARO, MD, LINA G	PHILADELPHIA
VARE JR, MD, VICTOR B	MONTGOMERY
VARGA, MD, JEFFREY M	ALLEGHENY
VARGA, MD, JULIE L	PHILADELPHIA
VARGAS, MD, DAVID J	PHILADELPHIA
VARINDANI, MD, MAHESH	ALLEGHENY
VARKER, MD, CAROLYN B	PHILADELPHIA
VARLEY, MD, WILLIAM A	ALLEGHENY
VARLEY, MD, WILLIAM J	ALLEGHENY
VARMA, MD, NEENA	DAUPHIN
VARMA, MD, RAJIV R	ALLEGHENY
VARON, MD, STUART R	ALLEGHENY
VASILY, MD, DAVID B	NORTHAMPTON
VASQUEZ, MD, JAVIER A	CUMBERLAND
VASSALLO, DO, FRANK A	PHILADELPHIA
VASSALLO, MD, RICHARD W	PHILADELPHIA
VASSALLO JR, MD, RALPH R	MONTGOMERY
VASSALLUZZO, MD, FRANCIS J	BUCKS
VASSALLUZZO, MD, JULIO E	BUCKS
VASSALLUZZO, DO, PETER D	PHILADELPHIA
VASTINE, MD, JOHN R	NORTHMBRLAND
VASUDEVAN, MD, GOPALAN	WESTMORELAND
VASUDEVAN, MD, RAGHAVAN	LYCOMING
VAUGHN, ANDREW F	STUDENT
VAUGHN JR, MD, ARTHUR R	PHILADELPHIA
VAYONIS, MD, ANDREW G	ALLEGHENY
VAZALES, MD, BRAD E	LANCASTER
VAZQUEZ, MD, JORGE	WASHINGTON
VAZQUEZ-ARAN, MD, ANNETTE	MONROE
VEGA, MD, ROGELIO E	ARMSTRONG
VEGARI, MD, MATT M	MONROE
VEGLIA, MD, ANTHONY P	SCHUYLKILL
VEGLIA, MD, KATHLEEN S	LUZERNE
VEKARIA, MD, KISHOR-KUMAR S	LACKAWANNA
VELAS, MD, CARLOS M	NORTHAMPTON
VELAYO, MD, DANTE P	UNION
VELEZ, MD, RAFAEL I	WESTMORELAND
VELEZ-RIVERA, MD, CARLOS A	PHILADELPHIA
VEMULAPALLI, MD, KUTUMBARAO	ERIE
VEMULAPALLI, MD, LAKSHMI R	ERIE
VENGROVE, DO, MARC A	NORTHAMPTON
VENIER, MD, LEON H	BERKS
VENIT, MD, BETHANY A	LUZERNE
VENKATESAN, MD, MALATHI	ALLEGHENY
VENTRE, MD, SUSAN	LACKAWANNA
VENTURA, MD, CECILIA R	LACKAWANNA
VENTURA, MD, SAMUEL R	LACKAWANNA
VEPURI, MD, VARALAXMI	BUCKS
VERDI, MD, CAROL A	PHILADELPHIA
VERGARA, MD, J ROBERTO	WAYNE/PIKE
VERGARE, MD, MICHAEL J	PHILADELPHIA
VERGARI, MD, JOHN A	PHILADELPHIA
VERGHESE, MD, CHERIAN	PHILADELPHIA
VERGIS, MD, EMANUEL N	ALLEGHENY
VERGIS, MD, JAMES G	BUCKS
VERMA, MD, MAHESHWER B	NORTHAMPTON
VERMA, MD, RAKESH C	BLAIR
VERMA, MD, RITU	PHILADELPHIA
VERMEIRE, MD, DAVID A	MERCER
VERNICK, MD, CLIFFORD G	LEHIGH
VERNICK, MD, JEROME J	PHILADELPHIA
VERNINO, DO, RICHARD JAMES	ALLEGHENY
VERNINO, MD, ROCCO A	ALLEGHENY
VERNOCY, MD, WILLIAM G	INDIANA
VERNON JR, MD, THOMAS M	PHILADELPHIA
VERONESI, DO, JOHN N	JEFFERSON
VERSAGE, MD, JOSEPH L	NORTHAMPTON
VERSTRAETEN, MD, THIERRY C	ALLEGHENY
VERTOSICK JR, MD, FRANK T	ALLEGHENY
VERY, MD, RONALD M	ALLEGHENY
VERZELLA, MD, JEFFREY N	LYCOMING
VESIO, MD, KENNETH D	ALLEGHENY
VETTER, MD, VICTORIA L	PHILADELPHIA
VEY, MD, EDWIN K	ALLEGHENY
VICKERS, MD, CURTIS W	COLUMBIA
VICKERY, JOHN P	STUDENT
VICKERY, MD, JON L	DAUPHIN
VICTOR, MD, MARK F	PHILADELPHIA
VICTOR, MD, STEPHEN J	MONTGOMERY
VIDOT, MILAGROS M	STUDENT
VIDOVICH, MD, DANKO V	ALLEGHENY
VIECHNICKI, MD, M BRUCE	LEHIGH
VIERA, MD, ANGEL	ALLEGHENY
VIERRA, MARK A	STUDENT
VIGDAROVICH, MD, VLADIMIR	NORTHMBRLAND
VIGIL, DEREK A	STUDENT
VIGILANTE, MD, MICHAEL	LEHIGH
VIGLIONE, MD, JOSEPH P	MONROE
VIGNERI, DO, PHILLIP M	LEHIGH
VIJAYAMOHAN, MD, GOVINDARAJULU	INDIANA
VIJAYKUMAR, MD, PUVALAI M	ALLEGHENY
VIKSMAN, MD, MICHAEL Y	PHILADELPHIA
VILLA, MD, FRANCISCO B	POTTER
VILLA, MD, GABRIELE L	BUCKS
VILLACRUSIS, MD, OSCAR C	LUZERNE
VILLANUEVA, MD, JESUS E	DELAWARE
VILLANUEVA, MD, STEVEN Y	BRADFORD
VILLANYI, MD, PAMELA J	MONROE
VILLANYI, MD, STEPHEN T	MONROE
VILLARE, MD, ANTHONY W	PHILADELPHIA
VILLAREAL, MD, DANIEL F	DELAWARE
VILLARREAL, MD, CARLOS X	SCHUYLKILL
VILLARS, MD, FREDERICK	BERKS
VILLAS, PETER A	STUDENT
VILLASIN, MD, JOSEPH V	LACKAWANNA
VILLAVICENCIO-NOCHE, MD, LYDIA L	FAYETTE
VILLEGAS, MD, ANTONIO C	MONTGOMERY
VILLEGAS, MD, EMILIO	WESTMORELAND
VILLELLA, MD, EDWARD R	ALLEGHENY
VILUSHIS, DO, GEORGE J	ERIE
VIN, MD, PRAKASH K	WESTMORELAND
VINCA, MARTIN J	STUDENT
VINCENS, MD, JAMES J	PHILADELPHIA
VINCENT, MD, GREGORY J	BUCKS
VINCENT, MD, JOSEPH E	LEHIGH
VINSON, MD, CAREY T	ALLEGHENY
VIOLA, MD, JOHN E	YORK
VIOLAGO, MD, EDUARDO S	DAUPHIN
VIQAR, MD, SYED H	MONTGOMERY
VIRAY, MD, NICK	LAWRENCE
VIRGILE, MD, ROGER S H	VENANGO
VISCUSI, MD, DONALD J	ERIE
VISNESKI, DO, PAUL E	LANCASTER
VISNICH JR, MD, NICHOLUS	ALLEGHENY
VISOT, MD, LUIS R	SCHUYLKILL
VISPERAS, MD, EMILIANA P	NORTHAMPTON
VISPERAS, MD, MARIO F	CARBON
VISWANATHAN, MD, AKILA N	STUDENT
VISWANATHAN, MD, BYRAVAN	ADAMS
VITANZA, DO, SEBASTIAN A	ERIE
VITTICHIRA, MD, SAJEEV P	PHILADELPHIA
VITTONE, MD, DANIEL C	WESTMORELAND
VITTONE, MD, RONALD B	WESTMORELAND
VITTONE, MD, ROSEMARY	ALLEGHENY
VIVIAN, MD, GAIL M	CHESTER
VIVINO, MD, FREDERICK B	PHILADELPHIA
VIZER, MD, MARK B	BUCKS
VIZZONI, JOSEPH A	STUDENT
VLAHOS, DO, PATRICK J	ALLEGHENY
VLESSING, MD, EVA	BUCKS
VOCI, MD, GERARDO	PHILADELPHIA
VOGAN, MD, CLIFFORD R	ARMSTRONG
VOGAN, MD, WILLIAM R	MERCER
VOGEL, MD, ERIC W	STUDENT
VOGEL JR, MD, JULIUS A	BEAVER
VOGELEY, MD, EVA A	ALLEGHENY
VOGIN, MD, EUGENE E	PHILADELPHIA
VOGLER JR, MD, WILFRED E	NORTHAMPTON
VOGT, MD, MERLE A	DELAWARE
VOGUS, MD, JAMES B	WARREN
VOHRA, MD, SURINDER PAL S	YORK
VOJTA, CHRISTOPHER L	STUDENT
VOLIN, MD, JAN J	MONTGOMERY
VOLK, MD, STEPHEN A	NORTHAMPTON
VOLKAR, MD, JUDITH K	CAMBRIA
VOLKIN, MD, LEONARD B	ALLEGHENY
VOLKIN, MD, ROBERT L	ALLEGHENY
VOLLMAR II, MD, WILLIAM R	LANCASTER
VOLOSKY, MD, ROBERT L	ALLEGHENY
VOLPE, MD, NICHOLAS J	PHILADELPHIA
VON RAGO, MD, LAWRENCE L	DAUPHIN
VONDERPORTEN, MD, KENNETH P	ALLEGHENY
VOORA, MD, SAMBASIVARAO	ERIE
VORA, MD, PRAFULLCHANDRA	GREENE
VORASINGHA, MD, THONGCHAI	PHILADELPHIA
VORE, MD, KIMBERLE K	WASHINGTON
VORE, MD, STEVEN B	CENTRE
VOSSENBERG, MD, FRANS J	MONTGOMERY
VOUTSINAS, MD, LOUISA V	LUZERNE
VOYCE, MD, STEPHEN J	LACKAWANNA
VOYE, DO, THOMAS E	MONTGOMERY
VOYSTOCK JR, MD, JOSEPH F	SCHUYLKILL
VOYTKO, MD, RICHARD E	CAMBRIA
VRABEC, MD, DONALD P	MONTOUR
VRABEC, MD, TAMARA R	PHILADELPHIA
VREELAND, MD, JAMES H	BEDFORD
VROOMAN, MD, SAMUEL C	PHILADELPHIA
VU, MD, KHANH H	PHILADELPHIA
VUJAN, MD, ALEXANDER S	ALLEGHENY
VUJEVICH, MD, MARION M	ALLEGHENY
VUJEVICH-WARD, DO, ANNE C	ALLEGHENY
VUKMER, MD, GEORGE J	VENANGO
VUKMER JR, MD, GEORGE J	CRAWFORD

W

WACHMAN, MD, JILL F	ALLEGHENY
WACHS, MD, HIRSH	ALLEGHENY
WADDINGTON, MD, ARTHUR W	PHILADELPHIA
WADDLE, DO, KEITH A	HUNTINGDON
WADE, MD, FRANKLIN G	LYCOMING
WADE, MD, GEORGE R	CHESTER
WADE, MD, JEANNE A	ERIE
WADE, MD, MARCIA J	ALLEGHENY
WADHWA, MD, KAMAL P	LAWRENCE
WADHWA, MD, RAJINDAR K	ALLEGHENY
WADHWANI, MD, BHAGWAN J	WASHINGTON
WADIH, MD, GEORGE E	MONTOUR
WAGENFUHR, MD, TIMM	CHESTER
WAGENHEIM, MD, HARRY H	PHILADELPHIA
WAGENHEIM, MD, HELEN S	PHILADELPHIA
WAGGENSPACK, MD, GERARD A	YORK
WAGMAN, MD, ALBERT D	PHILADELPHIA
WAGNER, MD, CHARLES I	MONTGOMERY
WAGNER, MD, DAVID K	PHILADELPHIA
WAGNER, MD, HENRY R	PHILADELPHIA
WAGNER, MD, J KENT L	LEBANON
WAGNER, MD, JERE L	NORTHMBRLAND
WAGNER, MD, JOHN B	BERKS
WAGNER, KRISTIN E	STUDENT
WAGNER, MD, KRISTINA M	DAUPHIN
WAGNER, MD, LOUIS J	LACKAWANNA
WAGNER, DO, PETER B	MONTGOMERY
WAGNER, MD, ROBERT A	VENANGO
WAGNER, MD, ROBERT E	ELK/CAMERON
WAGNER, MD, W JOHN	LYCOMING
WAGNER JR, MD, FREDERICK B	PHILADELPHIA
WAGNER JR, MD, RICHARD S	LANCASTER
WAHBA, MD, HANEY N	WESTMORELAND
WAHHAB, MD, ABDUL	SCHUYLKILL
WAHL, MD, JEFFREY M	CHESTER
WAHL, MD, LORETTA J	ALLEGHENY
WAHL, MD, MICHAEL J	ALLEGHENY
WAHRMAN, MD, JULIE E	BUCKS
WAIBEL, MD, DAVID A	LACKAWANNA
WAIBEL, MD, JOHN T	BLAIR
WALBERG, MD, HARRY W	ALLEGHENY
WALCYK, DO, PATRICIA J	BUCKS
WALCZAK, MD, KATHERINE L	ALLEGHENY
WALD, MD, NIEL	ALLEGHENY
WALDEN, MD, THOMAS B	NORTHAMPTON
WALDHAUSEN, MD, JOHN A	DAUPHIN
WALDMAN, MD, CLIFFORD R	ALLEGHENY
WALDMAN, MD, JOSEPH	PHILADELPHIA
WALDMAN, MD, SARAH E	PHILADELPHIA
WALDMAN, MD, SCOTT A	PHILADELPHIA
WALDMAN, MD, TERRY L	PHILADELPHIA
WALDO, MD, RALPH F	INDIANA
WALDOR, MD, PHILIP A	CHESTER
WALHEIM, MD, JON P	BUCKS
WALICHUCK, MD, JOHN G	DELAWARE
WALINSKY, MD, PAUL	PHILADELPHIA
WALKER, MD, ANDRZEJ R	DAUPHIN
WALKER, ANNE M	STUDENT
WALKER, MD, BARRY R	PHILADELPHIA
WALKER, MD, BRIAN K	CENTRE
WALKER, GREGORY E	STUDENT
WALKER, MD, HERBERT I	PHILADELPHIA
WALKER, MD, JAMES F	ERIE
WALKER, MD, JAMES L	DAUPHIN
WALKER, MD, JON G	LANCASTER
WALKER, MD, KIMBERLY C	PHILADELPHIA
WALKER, MD, LEVI	ALLEGHENY
WALKER, MD, M LORENZO	PHILADELPHIA
WALKER, MD, MARCELLUS A	WAYNE/PIKE
WALKER, MD, MARGARET E	PHILADELPHIA
WALKER, MD, ROBERT L	MONTOUR
WALKER, MD, STANLEY R	NORTHAMPTON
WALKER, MD, STEPHEN R	DELAWARE
WALKER, MD, WILLIAM R	LANCASTER
WALKER JR, MD, LEROY L	PHILADELPHIA
WALKOWSKI JR, MD, EDWARD J	LACKAWANNA
WALL, MD, JAMES R	LEHIGH
WALL, MD, JOHN N	ALLEGHENY
WALL, MD, NORMAN M	SCHUYLKILL
WALL, MD, ROD A	CAMBRIA
WALL, STEPHEN J	STUDENT
WALL, MD, THOMAS J	DAUPHIN
WALLACE, MD, IRA B	PHILADELPHIA
WALLACE, MD, RICHARD P	PHILADELPHIA
WALLACE, DO, WENDY J	PHILADELPHIA
WALLACE, MD, WILBUR S	ERIE
WALLACE JR, MD, JOSEPH	DELAWARE
WALLACH, MD, LAWRENCE	DELAWARE
WALLEN, MD, ROBERT C	MONROE
WALLENDJACK, MD, JOHN C	DAUPHIN
WALLER, MD, JOAN C	DELAWARE
WALLER, MD, LOUIS C	LACKAWANNA
WALLER, MD, LOUIS C	ALLEGHENY
WALLERSTEIN, MD, EDWARD M	ERIE
WALLEY III, MD, ROBERT E	ALLEGHENY
WALLIA, MD, RAJNI	ALLEGHENY
WALLICK, MD, PETER G	FRANKLIN

WALLIN, MD, THOMAS E	DAUPHIN
WALLISCH, MD, MICHAEL D	POTTER
WALLNER, DO, PAUL E	PHILADELPHIA
WALLS, DO, THERESA A	LANCASTER
WALMER, MD, JOHN D	LEBANON
WALN, CURTIS L	STUDENT
WALNISTA, MD, FRANK J	LACKAWANNA
WALOFF, MD, RONALD I	PHILADELPHIA
WALRATH III, MD, MARTIN H	ALLEGHENY
WALSH, MD, ARTHUR C	ALLEGHENY
WALSH, MD, DEIRDRE V	MONTGOMERY
WALSH, MD, JAMES C	LUZERNE
WALSH, MD, JOHN J	ALLEGHENY
WALSH, DO, JOHN R	DELAWARE
WALSH, MD, KATHLEEN I	MONTOUR
WALSH, MD, TIMOTHY P	FRANKLIN
WALSHIN, MD, DAVID B	BLAIR
WALTER, MD, C LEE	ALLEGHENY
WALTER, MD, DANIEL B	PHILADELPHIA
WALTER, MD, DAVID L	VENANGO
WALTER, MD, RICHARD D	LYCOMING
WALTER, MD, WILLIAM J	ALLEGHENY
WALTERS, MD, WILLIAM H	SCHUYLKILL
WALTERS, MD, WILLIAM S	WARREN
WALTHOUR, C SCOTT	STUDENT
WALTMAN, MD, CHARLES A	NORTHAMPTON
WALTMAN, MD, CLAIRE	YORK
WALTZ, MICHAEL D	STUDENT
WALTZ, MD, PAUL K	DAUPHIN
WALTZER, MD, FREDERICK N	MONTGOMERY
WAMPLER, MD, DAVID L	CUMBERLAND
WAMPLER, MD, M JOHN	YORK
WANAMAKER, MD, JOHN L	BRADFORD
WANCZYK, MD, CASIMIR J	BERKS
WANG, MD, BARBARA K	WESTMORELAND
WANG, MD, CHEE K	NORTHAMPTON
WANG, MD, EARL C	PHILADELPHIA
WANG, MD, HENRY Z	ALLEGHENY
WANG, MD, JOHN K	STUDENT
WANG, KATHY E	STUDENT
WANG, MD, KER-SHI	SCHUYLKILL
WANG, MD, KUAN-I	PHILADELPHIA
WANG, MD, MING X	PHILADELPHIA
WANG, MD, PETER T H	PHILADELPHIA
WANG, MD, SHEN-CHI	MERCER
WANG, MD, YAO C	LACKAWANNA
WANGLEE, DO, DEBORAH W	ALLEGHENY
WAPENSKI, MD, JOSEPH A	ALLEGHENY
WAPNER, MD, JOHN M	LEHIGH
WAPNER, MD, KEITH L	PHILADELPHIA
WARAVDEKAR, MD, NEIL V	DAUPHIN
WARD, MD, BARBARA H	ALLEGHENY
WARD, MD, CHARLES S	BEAVER
WARD, MD, EDGAR H	ERIE
WARD, MD, EDWARD J	DELAWARE
WARD, MD, H RICHARD	UNION
WARD, DO, JOHN R	ALLEGHENY
WARD, DO, JOSEPH J	PHILADELPHIA
WARD, MD, MARY J	COLUMBIA
WARD, MD, MICHAEL J A	CHESTER
WARD, MD, SAMUEL P	DAUPHIN
WARD, MD, STEPHEN D	MONTGOMERY
WARD, MD, TIMOTHY J	ERIE
WARD, MD, W TIMOTHY	ALLEGHENY
WARD, DO, WILLIAM L	PHILADELPHIA
WARD JR, MD, MAURICE J	CHESTER
WARD JR, MD, THOMAS D	WESTMORELAND
WARDE, MD, DONAL A	ALLEGHENY
WARDEN, MD, JAMES R	ERIE
WARE, MD, WILLIAM B	BEAVER
WARE, MD, WILLIAM C	DELAWARE
WARFEL, MD, BENJAMIN S	LANCASTER
WARFIELD, MD, ANNA S	DELAWARE
WARGO, MD, PETER J	ALLEGHENY
WARHOL, MD, MICHAEL J	PHILADELPHIA
WARIKOO, MD, SHIBAN K	CAMBRIA
WARK, MD, JAMES E	PHILADELPHIA
WARNER, MD, HOWARD F	PHILADELPHIA
WARNER, DO, MARIE J	MONTOUR
WARNER, MD, NORMAN M	CHESTER
WARNER, MD, ROBERT E	ALLEGHENY
WARNER, MD, ROBERT H	ALLEGHENY
WARNICK, MD, WILLIAM C	PHILADELPHIA
WARNING II, MD, WILLIAM J	DELAWARE
WARONKER, AMY S	STUDENT
WARREN, DAVID K	STUDENT
WARREN, MD, JONATHAN	NORTHAMPTON
WARREN, MD, KENNETH C	MONTGOMERY
WARREN, MD, WILBERT R	PHILADELPHIA
WARREN, MD, WILLIAM L	CHESTER
WARRENDER, MD, WILLIAM F	BUCKS
WASHBURN, MD, VIRGINIA E	ALLEGHENY
WASHINGTON, MD, BUFORD S	PHILADELPHIA
WASHINGTON, MD, E LACEY	PHILADELPHIA
WASILEWSKI JR, MD, CHARLES L	LYCOMING
WASKO, MD, MARGERY L	DAUPHIN
WASKO, MD, ROBERT	LEHIGH
WASNICK, MD, WILLIAM	LUZERNE
WASSEF, MD, YOUSSEF W	PHILADELPHIA
WASSERMAN, MD, HENRY	LEBANON
WASSERMAN, MD, KENNETH E	PHILADELPHIA
WASSERMAN, MD, ROBERT	PHILADELPHIA
WASSIL, MD, JOHN G	MERCER
WASSIL, MD, JOHN G	STUDENT
WASSIL JR, MD, JOHN G	MERCER
WASSON, MD, JAMES C	LEHIGH
WATERS, MD, MARK H	ALLEGHENY
WATERS, MD, MICHAEL N	ALLEGHENY
WATERS, DO, PATRICK T	PHILADELPHIA
WATKIN JR, MD, WALTER B	DAUPHIN
WATKINS, MD, GEORGE M	NORTHAMPTON
WATKINS, MD, GLORIA J	WESTMORELAND
WATKINS, MD, WALTER D	ALLEGHENY
WATKINS, WILLIAM L	STUDENT
WATSON, MD, BARBARA M	PHILADELPHIA
WATSON, MD, CHARLES G	ALLEGHENY
WATSON, MD, JAMES G	MONTGOMERY
WATSON, MD, JAMES R	ALLEGHENY
WATSON, MD, MARIA J	PHILADELPHIA
WATSON, MD, THOMAS G	SCHUYLKILL
WATSON, MD, WILLIAM GRAY	ALLEGHENY
WATSON III, MD, ROBERT A	PHILADELPHIA
WATSON-GRAY, KATHIE L	STUDENT
WATTENMAKER, MD, BERNARD M	ALLEGHENY
WATTERS, MD, EDMOND C	ALLEGHENY
WATTERSON, MD, SAMUEL G	SOMERSET
WAWROSE, MD, FREDERICK E	HUNTINGDON
WAY, MD, GEORGE E	CAMBRIA
WAY JR, DO, JAMES F	LYCOMING
WAYLONIS, MD, J ROBERT	ALLEGHENY
WEADER, MD, JOSEPH A	MONTOUR
WEADER, MD, WILLIAM M	NORTHMBRLAND
WEAN, MD, LAWRENCE P	DELAWARE
WEANER, DO, SCOTT M	BUCKS
WEASON, MD, STEVEN R	BUCKS
WEATHERBY III, MD, ELLSWORTH	BUCKS
WEAVER, MD, AARON R	LANCASTER
WEAVER, MD, AMY LU	CENTRE
WEAVER, MD, DON K	LYCOMING
WEAVER, MD, FRANK M	YORK
WEAVER, MD, GAYLE J	PHILADELPHIA
WEAVER, DO, GLENN E	LUZERNE
WEAVER, MD, JAMES D	ERIE
WEAVER, MD, JEAN M	CAMBRIA
WEAVER, MD, JEFFREY A	DAUPHIN
WEAVER, DO, JEFFREY G	ALLEGHENY
WEAVER, MD, KENT E	BERKS
WEAVER, MD, LUNDA E	BLAIR
WEAVER, MD, M FAY	BERKS
WEAVER, MD, MICHAEL A	DAUPHIN
WEAVER, MD, MILES L	ALLEGHENY
WEAVER, DO, RICHMAN G	YORK
WEAVER, MD, ROBERT G	BRADFORD
WEBB, MD, ELIZABETH S	MONTGOMERY
WEBBER, MD, CAROL P	MONTGOMERY
WEBBER, MD, JOHN B	PHILADELPHIA
WEBER, MD, DANIEL I	DAUPHIN
WEBER, MD, DAVID R	ALLEGHENY
WEBER, MD, GEORGE L	DELAWARE
WEBER, MD, JEFFREY K	WESTMORELAND
WEBER, MD, JOHN E	ALLEGHENY
WEBER, MD, JOHN I	PHILADELPHIA
WEBER, MD, LAWRENCE	ALLEGHENY
WEBER, MD, MARGARET ELLEN	PHILADELPHIA
WEBER, MD, OTTO R	MONROE
WEBER, MD, RICHARD H	LANCASTER
WEBER, MD, STANLEY	ALLEGHENY
WEBER, MD, STEVEN J	BUCKS
WEBER, DO, STUART A	MCKEAN
WEBER, MD, WILLIAM C	NORTHAMPTON
WEBSTER, MD, JOHN H	ALLEGHENY
WEBSTER, MD, LANE	TIOGA
WEBSTER, MD, MARSHALL W	ALLEGHENY
WEBSTER, MICHAEL L	STUDENT
WECHSLER, MD, LAWRENCE R	ALLEGHENY
WECHSLER, MD, RICHARD J	PHILADELPHIA
WECHSLER, MD, RICHARD L	ALLEGHENY
WECHT, MD, CYRIL H	ALLEGHENY
WEDEEN, MD, ROBERT S	CHESTER
WEDEMEYER, MD, ANNE L	ALLEGHENY
WEDEMEYER, MD, PHILLIPS P	ALLEGHENY
WEE, MD, ENG C	MERCER
WEED, MD, ALLEN S	MONTGOMERY
WEED, MD, MICHAEL K	LANCASTER
WEESE, MD, JAMES L	PHILADELPHIA
WEHBE, MD, MARWAN A	MONTGOMERY
WEHR, MATTHEW D	STUDENT
WEHRER, MD, JULIE A	ERIE
WEI, MD, LAWRENCE C	POTTER
WEI, MD, LAWRENCE M	ALLEGHENY
WEIBEL, MD, DAVID C	UNION
WEIBEL, MD, ROBERT E	DELAWARE
WEIBEL, MD, SANDRA B	PHILADELPHIA
WEIBEL, MD, TIMOTHY J	ERIE
WEIDA, MD, THOMAS J	LANCASTER
WEIDENHAMER, MD, MONICA L	ALLEGHENY
WEIDMAN, MD, DAVID A	ALLEGHENY
WEIDMAN, EXEC DIR, BRUCE R	BERKS
WEIDNER, MD, PAUL L	BUCKS
WEIDNER, MD, SANDRA L	BERKS
WEIGEL, MD, A LINN	ALLEGHENY
WEIGEL, MD, JESSE A	DAUPHIN
WEIGEL, MD, JOSEPH H	BEAVER
WEIGEL JR, MD, JOHN E	ALLEGHENY
WEIGHTMAN, MD, JOSEPH	UNION
WEIGLER, MD, RICHARD R	ALLEGHENY
WEIKERS, MD, NORBERT J	ALLEGHENY
WEIMER, MD, GREGORY R	CENTRE
WEIN, MD, ALAN J	PHILADELPHIA
WEIN, MD, THOMAS P	ALLEGHENY
WEINBAUM, MD, DAVID L	ALLEGHENY
WEINBERG, MD, CARROLL A	DELAWARE
WEINBERG, MD, DAVID S	PHILADELPHIA
WEINBERG, MD, J DAVID	LANCASTER
WEINBERG, MD, JOEL H	ALLEGHENY
WEINBERG, MD, MICHAEL G	WESTMORELAND
WEINBERG, MD, PAUL M	PHILADELPHIA
WEINBERG, MD, RICHARD A	DELAWARE
WEINBERG, MD, RICHARD L	ALLEGHENY
WEINBERGER, MD, IRVING G	ALLEGHENY
WEINBERGER, MD, MONTE B	ALLEGHENY
WEINBLATT, MD, FRED M	CHESTER
WEINBLATT, MD, HOWARD A	PHILADELPHIA
WEINER, MD, BRUCE	MONTGOMERY
WEINER, MD, FRANK	INDIANA
WEINER, MD, GERALD H	LAWRENCE
WEINER, MD, HAROLD M	MONTGOMERY
WEINER, DO, IRA H	DELAWARE
WEINER, MD, JACK	PHILADELPHIA
WEINER, MD, JEFFERY R	MONTGOMERY
WEINER, MD, LEON J	PHILADELPHIA
WEINER, MD, MARC H	LANCASTER
WEINER, MD, ROBERT A	MERCER
WEINGARTEN, MD, MARTIN Z	PHILADELPHIA
WEINGARTEN, MD, MICHAEL S	PHILADELPHIA
WEINGOLD, MD, DAVID H	LANCASTER
WEINSTEIN, MD, BARBARA J	ALLEGHENY
WEINSTEIN, MD, DAVID P	WESTMORELAND
WEINSTEIN, MD, GARY S	ALLEGHENY
WEINSTEIN, MD, GERALD S	ALLEGHENY
WEINSTEIN, MD, GREGORY S	PHILADELPHIA
WEINSTEIN, MD, JUDITH K	PHILADELPHIA
WEINSTEIN, MD, LEE	DAUPHIN
WEINSTEIN, MD, LISA F	PHILADELPHIA
WEINSTEIN, MD, ROBERT S	PHILADELPHIA
WEINSTOCK, MD, JEROME L	MONTGOMERY
WEINSTOCK, MD, ROBERT M	PHILADELPHIA
WEINTRAUB, MD, HARVEY	LUZERNE
WEINTRAUB, MD, RUSSELL	MCKEAN
WEIS, MD, PAUL R	LEHIGH
WEISBERG, MD, EDWARD S	ALLEGHENY
WEISBERG, MD, JEROME S	BERKS
WEISBERG, MD, PAUL B	PHILADELPHIA
WEISBERG, MD, ROBERT A	BUCKS
WEISEL, MD, WILLIAM M	WESTMORELAND
WEISENFLUH, MD, MARK G	ERIE
WEISER, MD, JEFFREY N	PHILADELPHIA
WEISER, MD, MADELEINE C	MONTGOMERY
WEISER, MD, PAUL J	BUCKS
WEISMAN, MD, HARLAN F	CHESTER
WEISMAN, MD, RICHARD A	ALLEGHENY
WEISMER, MD, RICHARD M	LANCASTER
WEISNER, MD, MICHAEL J	UNION
WEISS, MD, ALAN R	MONTGOMERY
WEISS, MD, ALBERT A	PHILADELPHIA
WEISS, MD, BURTON	PHILADELPHIA
WEISS, MD, CARL B	MONROE
WEISS, MD, DAVID J	PHILADELPHIA
WEISS, MD, EDWARD D	PHILADELPHIA
WEISS, MD, ELISSA	ALLEGHENY
WEISS, MD, FRED H	MONTGOMERY
WEISS, MD, GEORGE H	MONTGOMERY
WEISS, MD, JAMES	ALLEGHENY
WEISS, JEFFREY G	STUDENT
WEISS, MD, JEFFREY P	LACKAWANNA
WEISS, MD, JEFFREY P	PHILADELPHIA
WEISS, MD, JORDAN B	PHILADELPHIA
WEISS, DO, KENNETH S	MONTGOMERY
WEISS, MD, LAURENCE B	PHILADELPHIA
WEISS, MD, LAWRENCE E	PHILADELPHIA
WEISS, MD, MALCOLM S	ALLEGHENY
WEISS, MD, MICHAEL W	ALLEGHENY
WEISS, MD, RICHARD D	DELAWARE
WEISS, MD, ROBERT	PHILADELPHIA
WEISS, MD, ROBERT D	ALLEGHENY
WEISS, MD, ROBERT F	ALLEGHENY
WEISS, DO, ROBERT J	LEHIGH
WEISS, MD, ROBERT J	WARREN
WEISS, MD, ROBERTA A	MONTGOMERY
WEISS, MD, ROCHELLE R	PHILADELPHIA
WEISS, DO, ROGER T	FRANKLIN
WEISS, MD, SIDNEY	PHILADELPHIA
WEISS, MD, STEPHEN M	DAUPHIN
WEISS, MD, STEVEN J	PHILADELPHIA
WEISS, MD, WILLIAM	PHILADELPHIA
WEISS, MD, WILLIAM B	LUZERNE
WEISS JR, MD, CARL B	NORTHAMPTON
WEISSBACH, MD, NANCY E	ERIE
WEISSGOLD, MD, DAVID J	PHILADELPHIA
WEISSMAN, MD, JOEL M	PHILADELPHIA
WEISSMAN, MD, MARCUS I	PHILADELPHIA
WEITEKAMP, MD, MICHAEL R	DAUPHIN
WEITZEL, MD, WILLIAM K	ALLEGHENY
WEIZMAN, MICHAEL S	STUDENT
WELBY, MD, TIMOTHY D	MONTOUR
WELCH, MD, J PATRICK	LEBANON
WELCH, DO, WENDE A	ALLEGHENY
WELCH, MD, WILLIAM C	ALLEGHENY
WELDON, MD, JOHN F	WASHINGTON
WELDON, MD, JOHN P	ALLEGHENY
WELDON, DO, PATRICK O	ALLEGHENY
WELKIE, MD, JOHN F	LEHIGH
WELLENBACH, MD, BURTON L	PHILADELPHIA
WELLES, MD, RICHARD V	ERIE
WELLS, MD, E BUIST	ERIE
WELLS, MD, GREGG B	PHILADELPHIA
WELSCH, MD, FRANK A	BUCKS
WELSH, MD, JAMES F	BERKS
WEMPLE, MD, JAN B	NORTHAMPTON
WENDEL, DO, DANIEL T	ERIE
WENDEL, MD, MICHAEL J	LYCOMING
WENDELL JR, MD, JAMES I	MONTGOMERY
WENDER, MD, RICHARD C	PHILADELPHIA
WENDLING, MD, MARK A	STUDENT
WENDLING, MD, WOODROW W	PHILADELPHIA
WENG, MD, SAM S	NORTHAMPTON
WENGER, MD, ALLEN S	DAUPHIN
WENGER, MD, JAY A	BUCKS
WENGER, MD, MARLIN E	LANCASTER
WENGER, MD, NORMAN E	LACKAWANNA
WENGER, MD, SIDNEY U	PHILADELPHIA
WENGERT JR, MD, PAUL A	DAUPHIN
WENGROVITZ, MD, PAUL H	CENTRE
WENIGER, MD, FREDERICK C	ALLEGHENY
WENNER, DO, DAVID R	DAUPHIN
WENNER, MD, ROBERT B	LUZERNE
WENNER JR, DO, EARL J	YORK
WENNER JR, MD, WILLIAM J	PHILADELPHIA
WENOCUR, MD, HOWARD S	PHILADELPHIA
WENTZ, MD, HENRY S	LANCASTER
WENTZLER, MD, J DONALD	UNION
WERLEY, MD, CHARLES W	NORTHAMPTON
WERLEY, MD, JOHN D	NORTHAMPTON
WERNER, MD, A WILLIAM	ELK/CAMERON
WERNER, MD, ALAN M	ALLEGHENY
WERNER, MD, DAVID B	CENTRE
WERNER, MD, DONALD J	LACKAWANNA
WERNER, MD, ELLIOT B	PHILADELPHIA
WERNER, MD, JOYCE Z	CAMBRIA
WERNER, MD, ROBERT S	WAYNE/PIKE
WERNER JR, MD, JOSEPH H	BUCKS
WERRIN, MD, MARGUERITE W	CHESTER
WERRIN, MD, RONALD J	CHESTER
WERTHAN, MD, MERYLEE E	PHILADELPHIA
WERTHEIMER, MD, JOHN H	PHILADELPHIA
WERTHEIMER, MD, MARC J	DELAWARE
WERTIME, MD, CLARA G	DAUPHIN
WERTZ, DO, JAMES T	LEHIGH
WESCHLER, MD, BARBARA	ALLEGHENY
WESSEL, MD, ISADORE J	PHILADELPHIA
WESSNER-DUNLAP, DO, SUSAN L	MERCER
WEST, MD, EDWARD	CENTRE
WEST, MD, LESLEY S	CENTRE
WEST, MD, ROBERT B	MIFFLIN/JUNIATA
WEST, MD, THERESE B	PHILADELPHIA
WEST, MD, WILLIAM B	HUNTINGDON
WEST JR, MD, WILLIAM J	BERKS
WEST SR, MD, WILLIAM J	CUMBERLAND
WESTBY, MD, G RANDOLPH	DELAWARE
WESTCOTT, MD, RICHARD J	BERKS
WESTFIELD, WENDY K	STUDENT
WESTHEIM, MD, ALAN I	MONROE
WESTON, MD, JOHN M	UNION
WESTON, MD, WAYNE L	LACKAWANNA
WESTPHAL, MD, THOMAS R	LANCASTER
WETMORE, MD, RALPH F	PHILADELPHIA
WETMORE, MD, STANLEY M	DAUPHIN
WETSCHLER, MD, STANLEY S	ALLEGHENY
WETSTONE, MD, JEFFREY B	LYCOMING
WETTLAUFER, MD, MARILYN R	PHILADELPHIA
WETTON, MD, RITA	ALLEGHENY
WETZEL, DO, GEHRED D	LANCASTER
WETZEL, MD, MARIE A	BLAIR
WEXLER, MD, HARRY	PHILADELPHIA
WEXLIN, MD, DONALD J	MONTGOMERY
WEYN, MD, ADRIAN S	DELAWARE
WEYRICH, MD, TIMOTHY P	WASHINGTON
WHALEN, MD, THOMAS J	WASHINGTON
WHARTON, MD, KEITH H	ALLEGHENY
WHARTON, MD, STANLEY W	ERIE
WHEATLY, MD, WILLIAM K	LANCASTER
WHEELER, MD, GLEN N	LEBANON
WHEELER, MD, JENETTE H	MONTGOMERY
WHEELER, MD, JOHN S	LEHIGH
WHEELING, MD, GEORGE H	CAMBRIA
WHELAN, MD, STEPHEN T	DELAWARE
WHETSTONE, MD, CHARLES L	LANCASTER
WHILDIN, MD, JAMES G	NORTHAMPTON
WHINNEY, CHRISTOPHER M	STUDENT
WHIPPLE, MD, DOROTHY S	PHILADELPHIA
WHITAKER, MD, H CRAIG	DELAWARE
WHITAKER, MD, LINTON A	PHILADELPHIA
WHITAKER, MD, PAUL J	NORTHAMPTON
WHITCOMB, MD, CLARENCE A	PHILADELPHIA
WHITCOMB, MD, LUTHER M	CUMBERLAND
WHITCOPF, MD, PETER J	STUDENT
WHITE, MD, ALBERT E	BUCKS
WHITE, MD, CAROL J	GREENE
WHITE, MD, CHERYL JO	MONTGOMERY
WHITE, MD, DANETTE	PHILADELPHIA
WHITE, MD, DARYL E	FRANKLIN
WHITE, MD, DAVID A	WASHINGTON
WHITE, MD, GEORGE S	CENTRE
WHITE, MD, JACK C	CHESTER
WHITE, MD, JAMES W	LANCASTER
WHITE, JOHN E	STUDENT
WHITE, MD, JOSEPH G	CHESTER
WHITE, MD, KATHLENE	MONTGOMERY
WHITE, MD, MICHAEL J	ALLEGHENY
WHITE, MD, PETER F	CRAWFORD
WHITE, MD, RICHARD K	LEHIGH
WHITE, MD, ROBERT A	DELAWARE
WHITE, MD, ROBERT P	NORTHAMPTON
WHITE, MD, WAYNE D	DAUPHIN
WHITE, MD, WESLEY R	LACKAWANNA
WHITE, MD, WILLIAM L	ALLEGHENY
WHITE, EXEC SEC, ANNE L	FAYETTE
WHITE III, RICHARD J	STUDENT
WHITE JR, MD, ROBERT H	LANCASTER
WHITEBLOOM, DO, DALE	LANCASTER
WHITELEY, MD, JOHN P	YORK
WHITENACK, MD, STEPHEN H	PHILADELPHIA
WHITESIDE, DEBORAH A	STUDENT
WHITING, MD, DONALD M	ALLEGHENY
WHITING, MD, R KEITH	LEBANON
WHITMAN, MD, MARK A	BUCKS
WHITMAN, MD, RANDAL L	PHILADELPHIA
WHITMAN, MD, ROBERT S	ALLEGHENY
WHITMER, MD, JEFFREY T	BUCKS
WHITMORE, MD, JOHN T	BEDFORD
WHITMORE, MD, MASON	DELAWARE
WHITNEY, MD, JONATHAN P	DAUPHIN
WHITNEY, MD, MARK B	CUMBERLAND
WHITSON, MD, DAVID W	LEHIGH

WHITTAKER, MD, RICHARD P	MONTGOMERY
WHITTLE, MD, DONNA I	ALLEGHENY
WHOLEY, MD, MARK H	ALLEGHENY
WHYTE, MD, JOHN	PHILADELPHIA
WIBLE, MD, CLAIRE E	YORK
WIBLE, MD, LEROY C	ALLEGHENY
WIBOON, DO, BRIAN K	PHILADELPHIA
WICKRAMASINGHE, MD, EARDLY K	ERIE
WIDDOWSON, MD, HAROLD R	DELAWARE
WIDELITZ, MD, MARTIN M	PHILADELPHIA
WIDER, MD, SAUL	PHILADELPHIA
WIDGE, MD, TOERUNA S	LEHIGH
WIDGER, MD, JOHN E	COLUMBIA
WIDLAN, MD, SHELDON	WESTMORELAND
WIDRA, MD, ERIC A	PHILADELPHIA
WIECKS, MD, MICHAEL J	DAUPHIN
WIECZOREK, BRIAN J	STUDENT
WIEDER JR, MD, HENRY S	PHILADELPHIA
WIEGAND, MD, DAVID A	DAUPHIN
WIEGAND, MD, PAUL J	ALLEGHENY
WIEGAND, ROSEMARY A	STUDENT
WIELAND, MD, WINFRIED G	LANCASTER
WIEMANN, MD, GEORGE F	BUCKS
WIENER, MD, EUGENE S	ALLEGHENY
WIENER, MD, JACOB S	PHILADELPHIA
WIENER, DO, STEPHEN D	MONTGOMERY
WIENER, MD, STEPHEN G	BERKS
WIESENFELD, MD, HAROLD C	ALLEGHENY
WIESENFELD, MD, NATHANIEL H	LUZERNE
WIESNER, MD, IRVING S	DELAWARE
WIEST, MD, HIRAM L	DAUPHIN
WIGERT, MD, WALTER S	TIOGA
WIGHT, MD, SUSAN C	PHILADELPHIA
WIGLE, MD, ARNOLD R	WESTMORELAND
WIJESINGHE, HIRAN S	STUDENT
WIKERT, MD, GARY A	BEDFORD
WIKLER, MD, LOUIS A	PHILADELPHIA
WIKLER, MD, MATTHEW A	PHILADELPHIA
WIKOFF, MD, EDWARD K	PHILADELPHIA
WILBERGER JR, MD, JAMES E	ALLEGHENY
WILBUR, MD, SABRINA L	PHILADELPHIA
WILCOX, MD, GEOFFREY H	ALLEGHENY
WILCOX, MD, JULIA W	ALLEGHENY
WILCOX, MD, KENNETH R	LACKAWANNA
WILCOX, MD, SIMON L	BEAVER
WILCOX JR, MD, WINTHROP P	LANCASTER
WILCZANSKI, MD, PETER L	ERIE
WILD JR, MD, ROBERT M	CENTRE
WILDBLOOD, MD, HARRY M	YORK
WILDER, MD, BRUCE L	ALLEGHENY
WILDERMAN, MD, BARRY S	BUCKS
WILDRICK, MD, KENNETH H	NORTHAMPTON
WILEN, MD, HOWARD O	ALLEGHENY
WILEY, MD, BERT C	BLAIR
WILEY, MD, CATHERINE C	PHILADELPHIA
WILEY, DO, DAVID E	LANCASTER
WILF, MD, HAROLD	PHILADELPHIA
WILHELM, MD, BARBARA E	FAYETTE
WILHELM, MD, MAUREEN M	PHILADELPHIA
WILHELM, MD, WILLIAM C	ERIE
WILKENING, MD, ROBIN M	MIFFLIN/JUNIATA
WILKENS, MD, JILL C	PHILADELPHIA
WILKERSON, MD, CARLOS J	PHILADELPHIA
WILKERSON, MD, L DOUGLAS	MONTGOMERY
WILKERSON, MD, LORNA A	ALLEGHENY
WILKES, MD, DAWN C	LEHIGH
WILKES, MARGARET M	STUDENT
WILKINS, MD, BYRON D	LEHIGH
WILKINSON, MD, HAROLD A	DELAWARE
WILKINSON, MD, JOHN H	ALLEGHENY
WILKINSON, JOHN J	STUDENT
WILKINSON, MICHELLE E	STUDENT
WILKINSON, MD, ROSELISE H	DELAWARE
WILKS, MD, DAVID H	ALLEGHENY
WILLARD III, MD, WILLIS W	CUMBERLAND
WILLCOX JR, MD, THOMAS O	PHILADELPHIA
WILLENBORG, MD, ANNE	CENTRE
WILLIAMS, MD, A CLAUDE	LYCOMING
WILLIAMS, MD, ANDRE' O	CHESTER
WILLIAMS, MD, BRENDA A	ALLEGHENY
WILLIAMS, MD, BRIAN A	ALLEGHENY
WILLIAMS, MD, BURTON L	DELAWARE
WILLIAMS, MD, CHRISTOPHER A	DELAWARE
WILLIAMS, MD, CLAUDE M	DELAWARE
WILLIAMS, DO, DAVID T	CAMBRIA
WILLIAMS, MD, ELIZABETH A	PHILADELPHIA
WILLIAMS, MD, F MARIAN	PHILADELPHIA
WILLIAMS, MD, GLENN R	YORK
WILLIAMS, MD, GREGORY S	CHESTER
WILLIAMS, MD, HARRY K	ALLEGHENY
WILLIAMS, MD, HENRY N	LANCASTER
WILLIAMS, MD, HERMAN J	BERKS
WILLIAMS, MD, JAMES R	PHILADELPHIA
WILLIAMS, MD, JAY JAMES	PHILADELPHIA
WILLIAMS, MD, JOHN J	BERKS
WILLIAMS, JOHN M	STUDENT
WILLIAMS, MD, JOHN T	PHILADELPHIA
WILLIAMS, MD, KARL E	ALLEGHENY
WILLIAMS, MD, KEITH N	STUDENT
WILLIAMS, MD, KIRKLEY R	PHILADELPHIA
WILLIAMS, MD, LYNN R	LAWRENCE
WILLIAMS, DO, MARK S	WESTMORELAND
WILLIAMS, MD, MELVIN C	INDIANA
WILLIAMS, MD, MICHAEL J	PHILADELPHIA
WILLIAMS, MD, NORMAN S	ALLEGHENY
WILLIAMS, DO, PAUL D	DAUPHIN
WILLIAMS, MD, R HALLOCK	MONTGOMERY
WILLIAMS, MD, RICHARD A	ERIE
WILLIAMS, MD, RICHARD G	CLEARFIELD
WILLIAMS, MD, SHELLEY D	ALLEGHENY
WILLIAMS, MD, STEPHEN K	MONTGOMERY
WILLIAMS, MD, STEVEN C	ALLEGHENY
WILLIAMS, MD, SUSAN L	DELAWARE
WILLIAMS, MD, VIRGINIA M	DAUPHIN
WILLIAMS III, MD, IRVING	UNION
WILLIAMS JR, MD, PHILIP D	ALLEGHENY
WILLIAMS JR, MD, THOMAS L	NORTHAMPTON
WILLIAMSON, MD, CLARKE E	PHILADELPHIA
WILLIAMSON, MD, EDWARD L	WESTMORELAND
WILLIAMSON, MD, MARK E	ALLEGHENY
WILLIAMSON, MD, NEIHL J	LYCOMING
WILLIG, MD, DORIS	PHILADELPHIA
WILLIHNGANZ, MD, WALTER D	BUCKS
WILLIS, PAUL M	STUDENT
WILLNER, MD, DAVID L	CHESTER
WILLOCHELL, MD, TERI A	STUDENT
WILLS, MD, H DONALD	LEHIGH
WILLS, MD, MICHAEL H	LANCASTER
WILLS, MD, ROSELYN A	BUCKS
WILLWERTH, MD, GERALD E	FRANKLIN
WILSON, MD, AUDREY R	PHILADELPHIA
WILSON, MD, DAVID G	YORK
WILSON, MD, DAVID O	ALLEGHENY
WILSON, MD, DONALD F	CHESTER
WILSON, MD, DOROTHY G	NORTHMBRLAND
WILSON, MD, DOUGLAS G	ALLEGHENY
WILSON, DO, FREDERICK R	MERCER
WILSON, MD, FREDERICK S	MONTGOMERY
WILSON, MD, GEORGE M	PHILADELPHIA
WILSON, MD, GEORGE W	ALLEGHENY
WILSON, MD, J EDWARD	DAUPHIN
WILSON, MD, JAMES A	LANCASTER
WILSON, MD, JOHN F	PHILADELPHIA
WILSON, MD, JOHN S	WESTMORELAND
WILSON, MD, JOHN S	ALLEGHENY
WILSON, MD, LANCE B	BUCKS
WILSON, LAURALEE	STUDENT
WILSON, MD, LINDA C	CHESTER
WILSON, MD, RAY A	YORK
WILSON, MD, RICHARD A	ARMSTRONG
WILSON, MD, RICHARD C	LEHIGH
WILSON, MD, RICHARD P	PHILADELPHIA
WILSON, DO, ROBERT E	ALLEGHENY
WILSON, MD, ROBERT V	YORK
WILSON, MD, SAMUEL M	PHILADELPHIA
WILSON, STEPHEN A	STUDENT
WILSON, MD, THOMAS W	LAWRENCE
WILSON, MD, W LAWRENCE	ALLEGHENY
WILSON, MD, WILLIAM W	MONTGOMERY
WILSON JR, MD, CHARLES R	ALLEGHENY
WILSON JR, MD, ROBERT N	MONTGOMERY
WILT, MD, KENNETH E	YORK
WILTSHIRE-SCOTT, MD, JOANNE A	STUDENT
WINAND, MD, ANDREW T	YORK
WINAND, DAVID A	STUDENT
WINANS, MD, LEWIS E	BERKS
WINEBERG, JENNIFER R	STUDENT
WINER, MD, JOEL W	YORK
WINER, MD, STEPHEN F	LEBANON
WINEY, MD, WILFRED H	CAMBRIA
WING, MD, EDWARD J	ALLEGHENY
WINGARD, MD, LARRY B	ARMSTRONG
WINGATE, MD, GARY F	CHESTER
WINGERD, MD, ROBERT A	FRANKLIN
WINGERT JR, MD, CHARLES H	CENTRE
WINGERT JR, MD, J PAUL	BLAIR
WINIARSKI, MD, GENEVIEVE C	LANCASTER
WINKLER, MD, MARTIN	ALLEGHENY
WINKLER JR, MD, LOUIS H	NORTHAMPTON
WINN, MD, RANDALL S	BERKS
WINN JR, MD, CHARLES L	BUCKS
WINNEG, MD, KAREN P	BUCKS
WINSLOW, MD, ROY E	FRANKLIN
WINSTON, MD, JOSEPH M	BERKS
WINSTON, MD, NORMAN J	BERKS
WINSTON, MD, RALPH B	BRADFORD
WINT, MD, ROGER M	PHILADELPHIA
WINTER, MD, CHARLES R	LANCASTER
WINTER, MD, FRED S	MONTGOMERY
WINTER, MD, PETER M	ALLEGHENY
WINTER II, MD, JOHN C	LYCOMING
WINTERS, DO, ELIZABETH A M	BUCKS
WINTZ, MD, PHYLLIS W	ALLEGHENY
WIRE, MD, WILBUR H	YORK
WIRTH, MD, TIMOTHY M	BERKS
WIRTS JR, MD, C WILMER	PHILADELPHIA
WISE, MD, RICHARD J	LUZERNE
WISELY, DO, DENISE	PHILADELPHIA
WISEMAN, DO, DOUGLAS C	NORTHAMPTON
WISGO, MD, CHRISTOPHER J	PHILADELPHIA
WISMAN, MD, CRAIG B	DAUPHIN
WISNIEWSKI, MD, PETER M	LUZERNE
WISS, MD, RAYMOND J	CUMBERLAND
WISSINGER, MD, H ANDREW	ALLEGHENY
WISSLER, MD, ROBERT U	LANCASTER
WITHAM, MD, REBECCA S	DELAWARE
WITHERSPOON, MD, JOHN S	ALLEGHENY
WITHERSPOON, MD, MYRA A	CUMBERLAND
WITHERSPOON, MD, ROBERT G	WESTMORELAND
WITHINGTON, MD, AMELIA M	PHILADELPHIA
WITKES, DO, DAVID M	CAMBRIA
WITKIN, MD, EVELYN D	MONTGOMERY
WITKOWSKI, MD, JOSEPH A	PHILADELPHIA
WITKOWSKI, MD, THOMAS A	PHILADELPHIA
WITLIN, DO, ANDREA G	ALLEGHENY
WITMER, MD, DONALD B	LANCASTER
WITMER, MD, ROBERT H	LANCASTER
WITOWSKI, MD, JOHN J	LACKAWANNA
WITT, MD, DEBORAH K	PHILADELPHIA
WITT, MD, PAUL J	LUZERNE
WITTELS, MD, EMANUEL	BERKS
WITTELS, MD, HEIDI L	PHILADELPHIA
WITTERHOLT, MD, KENNETH A	CHESTER
WITTHOFF JR, MD, ELMER M	LYCOMING
WITTIG, MD, ROBERT L	ALLEGHENY
WITTMANN, MD, THOMAS A	ERIE
WODA, MD, ANNEMARIE L	PHILADELPHIA
WODLINGER, MD, PAUL M	WASHINGTON
WODZINSKI, MD, STEVEN F	WESTMORELAND
WOELFEL, MD, GEORGE F	ALLEGHENY
WOERTHWEIN, MD, KENNETH F	YORK
WOHL, MD, MILTON A	PHILADELPHIA
WOHL-KRISTO, MD, CATHERINE V	DELAWARE
WOHLTMANN, MD, CHRISTOPHER D	BRADFORD
WOJCIAK, DO, RAYMOND J	ALLEGHENY
WOLANIN, MD, JANUSZ	LUZERNE
WOLBACH JR, MD, ALBERT B	LANCASTER
WOLDORF, MD, NORMAN M	DAUPHIN
WOLDOW, MD, ANDREW B	MONTGOMERY
WOLDOW, MD, ASHER	PHILADELPHIA
WOLF, MD, CHARLES R	CHESTER
WOLF, ELIZABETH A	STUDENT
WOLF, ERICA	STUDENT
WOLF, MD, FRANKLIN M	BERKS
WOLF, MD, LAURENCE R	MONTGOMERY
WOLF, MD, LEWIS R	PHILADELPHIA
WOLF, MD, MELVYN A	MONTGOMERY
WOLF, MD, NELSON M	PHILADELPHIA
WOLF, MD, ROBERT E	DAUPHIN
WOLF, MD, SANDRA M	PHILADELPHIA
WOLF, MD, STEWART G	NORTHAMPTON
WOLF III, ALBERT A	STUDENT
WOLF JR, MD, JOHN H	PHILADELPHIA
WOLFE, MD, DANIEL E	LYCOMING
WOLFE, MD, DWIGHT D	LANCASTER
WOLFE, MD, JUDITH A	CAMBRIA
WOLFE, MD, PATRICK W	CAMBRIA
WOLFERT, MD, IRWIN H	MONTGOMERY
WOLFERTH JR, MD, CHARLES C	PHILADELPHIA
WOLFF, MD, CHARLES R	ALLEGHENY
WOLFF, MD, DANIEL C	SUSQUEHANNA
WOLFF, MD, JEFFREY M	WESTMORELAND
WOLFF, MD, REGIS A	ALLEGHENY
WOLFGANG, CHRISTOPHER	STUDENT
WOLFGANG, MD, GARY L	MONTOUR
WOLFINGER, MD, WALTER L	FRANKLIN
WOLFORD, MD, JACK A	ALLEGHENY
WOLFORD, DO, MICHAEL G	MERCER
WOLFSON, MD, BERNARD	ALLEGHENY
WOLFSON, MD, PHILIP J	PHILADELPHIA
WOLFSON, MD, ROBERT J	PHILADELPHIA
WOLFSON, MD, STEVEN J	LYCOMING
WOLGEMUTH JR, MD, JOHN M	LANCASTER
WOLGIN, MD, WILLIAM	PHILADELPHIA
WOLINSKY, MD, ARTHUR P	ALLEGHENY
WOLK, MD, DANIEL L	DELAWARE
WOLK, MD, MELVYN H	LACKAWANNA
WOLK, MD, MICHAEL D	LACKAWANNA
WOLK, MD, STEPHEN M	LUZERNE
WOLLMAN, MD, HARRY	PHILADELPHIA
WOLLMAN, MD, MICHAEL R	ALLEGHENY
WOLMARK, MD, NORMAN	ALLEGHENY
WOLOSHIN, MD, HENRY J	PHILADELPHIA
WOLYNN, MD, TODD H	ALLEGHENY
WOLZ, MD, DEAN E	ALLEGHENY
WOMER, MD, RICHARD B	PHILADELPHIA
WON, MD, A W PETER	ERIE
WON, MD, KWAN H	DAUPHIN
WON, MD, OKHEE	LACKAWANNA
WONG, MD, ALBERT	SOMERSET
WONG, MD, ALEXANDER	SUSQUEHANNA
WONG, CARRIE C	STUDENT
WONG, MD, EDGAR	TIOGA
WONG, MD, HENRY C	MONROE
WONG, MD, HON YUEN	CLARION
WONG, MD, JAMES	BERKS
WONG, MD, KIN TUNG	PHILADELPHIA
WONG, MD, LING G	CENTRE
WONG, MD, MING-DER	YORK
WONG, ROBERT F	STUDENT
WONG, MD, STEPHEN W	PHILADELPHIA
WONG, MD, TIEN PEI	MONTGOMERY
WONGPAKDEE, MD, SOBSAN	POTTER
WONSETTLER, MD, DONALD E	MERCER
WOO, BENEDICT C	STUDENT
WOO, EDWARD Y	STUDENT
WOO, MD, MARIANO	YORK
WOOD, MD, DAVID W	MONTGOMERY
WOOD, MD, ERNEST M	LANCASTER
WOOD, MD, HOWARD P	MONTGOMERY
WOOD, MD, JAMES E	PHILADELPHIA
WOOD, MD, JOHN M	ALLEGHENY
WOOD, LAURA M	STUDENT
WOOD, MD, MADELINE S	DELAWARE
WOOD, MD, MARGARET D	PHILADELPHIA
WOOD, RANDOLPH B	STUDENT
WOODBURY, MD, DEBORAH	MONTGOMERY
WOODINGS, MD, SAMUEL G	MERCER
WOODLAND, MD, MARK B	PHILADELPHIA
WOODLE, DO, EDWARD M	INDIANA
WOODMAN, MD, THOMAS J	BUCKS
WOODRUFF JR, MD, D STRATTON	MONTGOMERY
WOODS, MD, ANNE M	YORK
WOODS, MD, EDWARD L	MONTOUR
WOODS, KELLY WAYNE	STUDENT
WOODS, MD, TIMOTHY A	PHILADELPHIA
WOODS, TIMOTHY G	STUDENT
WOODSIDE, MD, JOHN A	YORK
WOODSON, MD, ROBERT H	PHILADELPHIA
WOODWARD, MD, EDWARD G	DAUPHIN
WOODWARD, MD, JOHN P	PHILADELPHIA
WOOMERT, MD, CATHLEEN A	MONTOUR
WOOTEN, MD, SALLY M	MIFFLIN/JUNIATA
WORKS, MD, KIRK L	MERCER
WORLEY, MD, CARL M	ALLEGHENY
WORLEY, MD, SETH J	LANCASTER
WORNAS, MD, CHRISTIAN G	BERKS
WOROBEC, MD, RUSSELL N	LYCOMING
WORRALL, MD, V THOMAS	ALLEGHENY
WORRILOW, MD, CHARLES C	PHILADELPHIA
WORRILOW, MD, SUZANNE H	LEBANON
WORSEY, MD, MICHAEL J	ALLEGHENY
WORSHTIL, MD, MARK E	WASHINGTON
WORTHINGTON, MD, JOHN J	MONTGOMERY
WORTZEL, MD, RICHARD D	BUCKS
WORTZEL, MD, SANDRA H	BUCKS
WOTRING, MD, JOHN M	BERKS
WOYNAROWSKI, MD, DAVID M	BERKS
WOYNAROWSKI, MD, JOHN A	BERKS
WOZNIAK, MD, RICHARD S	CAMBRIA
WRIGHT, MD, BRUCE A	ALLEGHENY
WRIGHT, MD, DAVID G	ALLEGHENY
WRIGHT, MD, DEBORAH S	BUCKS
WRIGHT, GEOFFREY A	STUDENT
WRIGHT, MD, L ALAN	ALLEGHENY
WRIGHT, MD, LIBBYETTE E	ALLEGHENY
WRIGHT, DO, MATTHEW L	ALLEGHENY
WRIGHT, MD, RAYFORD E	CAMBRIA
WRIGHT, MD, RICHARD E	ALLEGHENY
WRIGHT, MD, ROBERT E	LACKAWANNA
WRIGHT, MD, THOMAS S	MONTGOMERY
WRIGHT, MD, WILLIAM C	COLUMBIA
WRIGHT, MD, WILLIAM R	LAWRENCE
WRIGHT JR, MD, ALFRED E	FAYETTE
WRIGHT JR, MD, GEORGE J	ALLEGHENY
WRIGHT JR, MD, JOHN C Y	BEAVER
WRIGLEY, MD, MICHAEL S	MONTGOMERY
WROBLEWSKI, MD, GENEVIEVE A	LUZERNE
WU, MD, JUN-YI	LACKAWANNA
WU, MD, KENNETH D	PHILADELPHIA
WU, MICHAEL C	STUDENT
WU, MD, TSUNG-TEH	ALLEGHENY
WUKICH, MD, DANE K	NORTHAMPTON
WULC, MD, ALLAN E	MONTGOMERY
WUMMER, MD, BRIAN A	BERKS
WUSHENSKY, MD, CURTIS A	CHESTER
WUSTROW, MD, H JUERGEN	BLAIR
WYDAN, MD, ANTHONY G	MONTGOMERY
WYDRO, MD, GERALD C	STUDENT
WYLIE, MD, MARY E	ALLEGHENY
WYLONIS, MD, LAUREN J	STUDENT
WYNERT, MD, WILLIAM R	CAMBRIA
WYNKOOP, WALTER A	STUDENT
WYNNE, HEATHER N	STUDENT
WYSHOCK, MD, EDWARD G	LYCOMING
WYSZOMIERSKI, MD, DAVID A	WESTMORELAND

X

XANTHOPOULOS, DO, JAMES E	MIFFLIN/JUNIATA
XAVIER, MD, CHERIAN P	PHILADELPHIA
XU, ANLIN	STUDENT

Y

YACONO, MD, JOHN V	ALLEGHENY
YAEGER, MD, THOMAS A	BRADFORD
YAGER JR, DO, ROBERT G	LUZERNE
YAGNIK, MD, PRATAP M	DELAWARE
YAGNIK, MD, REKHA P	DELAWARE
YAKISH, MD, JACK E	ERIE
YAKISH, MD, SAMUEL D	BEAVER
YAMULLA, MD, ROBERT S	LUZERNE
YAMULLA, MD, STANLEY J	LUZERNE
YANCHUS, MD, ROBERT M	ALLEGHENY
YANG, MD, JAE-TAEK	ARMSTRONG
YANG, MD, JAU-HSIN	ALLEGHENY
YANG, MAXIMILLIAN Y	STUDENT
YANG, MD, SHUIN-LIN	PHILADELPHIA
YANG, MD, UN-TAEK	MONTGOMERY
YANG, MD, WEN-SHIONG	LEHIGH
YANG, MD, WILLIAN	MONTGOMERY
YANICKO JR, MD, DANIEL R	MERCER
YANITY, MD, EUGENE J	MONTGOMERY
YANKELEVICH, MD, RAUL	PHILADELPHIA
YANKURA, MD, JOHN A	ALLEGHENY
YANNACCONE, MD, ROBERT	UNION
YANOFF, MD, DAVID B	LEHIGH
YANOFF, MD, MYRON	PHILADELPHIA
YANOFSKY, MD, CHARLES S	DAUPHIN
YANOSCHAK, JENNIFER L	STUDENT
YANOVIAK, DO, FRANCIS J	UNION
YANOVSKI, MD, A VIVIAN	PHILADELPHIA
YANOVSKI, MD, ALEXANDER G	PHILADELPHIA
YAO, MD, YVONNE A	ALLEGHENY
YARBORO, MD, THEODORE L	MERCER
YARDNEY, MD, MARC J	DELAWARE
YARDUMIAN, DO, JOHN	MONTGOMERY
YARNALL, MD, G WINFIELD	DAUPHIN
YARON, MD, NOEMI S	DELAWARE
YAROS, MD, JOHN G	ALLEGHENY
YARRA, MD, NIRMALA	PHILADELPHIA
YARROW, MD, MORRIS W	PHILADELPHIA
YARTZ, DO, FRANK C	LYCOMING
YARUS, DO, LANCE O	LEBANON
YARWOOD, MD, ROBERT L	LANCASTER
YASUI, MD, ROBERT S	LYCOMING
YASWINSKI JR, MD, PETER T	MONROE
YATES, MD, ADOLPH J	ALLEGHENY
YATES, MD, ANTHONY P	ALLEGHENY
YATES, MD, JAMES A	DAUPHIN
YATES, MD, WILLIAM A	CAMBRIA

YAUCH, MD, JOHN A	ALLEGHENY
YAVIL, DO, JULES S	PHILADELPHIA
YAVOREK, MD, AMY	LACKAWANNA
YAVOREK JR, MD, HENRY G	NORTHMBRLAND
YAW, MD, KENNETH M	ALLEGHENY
YAZDANFAR, MD, SHAHRIAR	PHILADELPHIA
YAZDI, MD, JOSEPH S	STUDENT
YE, MD, KEN	PHILADELPHIA
YE, MD, ZHONG	NORTHAMPTON
YEAGER, MD, HENRY C	LACKAWANNA
YEAGER, MD, JAMES P	CUMBERLAND
YEAGLEY, MD, HEBER E	BERKS
YEAKEL, MD, ALLEN E	LANCASTER
YEALY, MD, W HOLMES	LYCOMING
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Women in Medicine

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What Has the Federation of Medicine Done for You Lately?
See page 22 for a recap of the "victories" recently won by your State Society and the Federation of Medicine.

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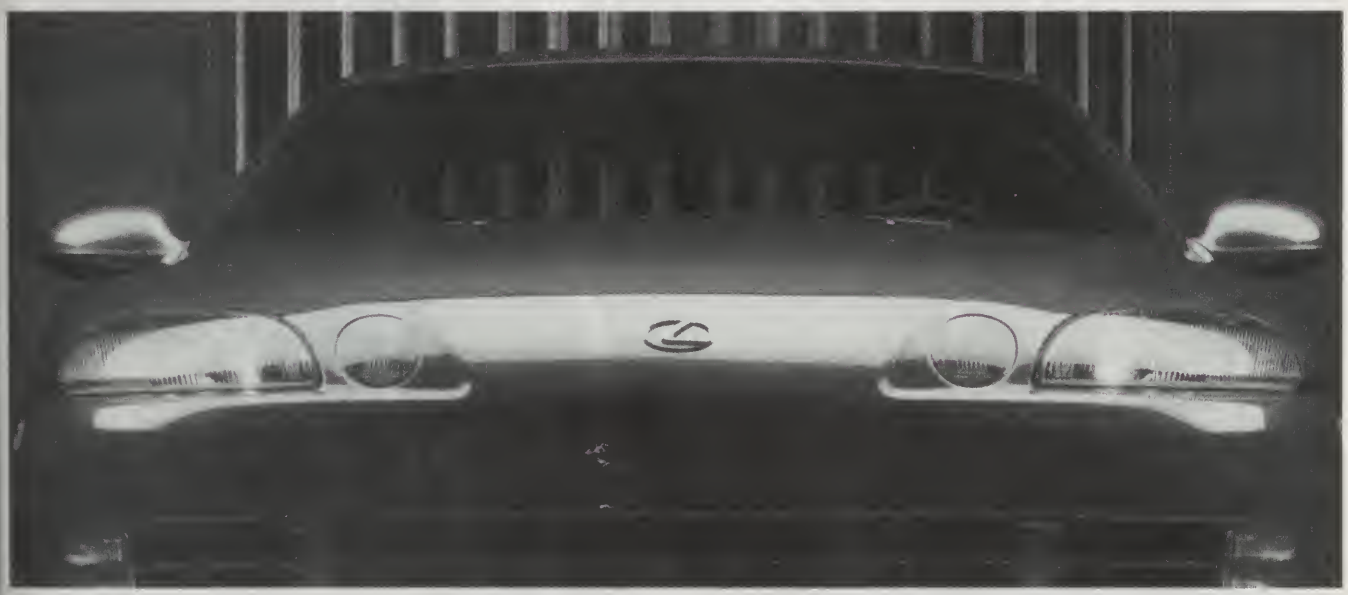

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Women in Medicine: A Brighter Future for All

The American Medical Association designates each September as Women in Medicine Month—a time to celebrate the achievements of women physicians and to promote the increasing opportunities for women in organized medicine and the profession. Coverage includes:

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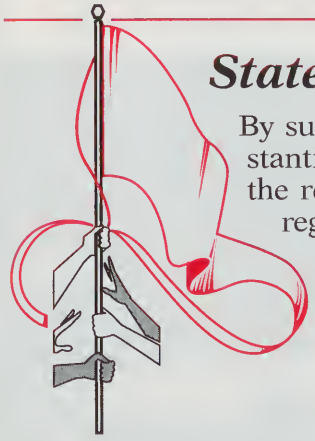

State Society Scores Wins

By summer's end, the Society had tallied substantial savings for Pennsylvania physicians as the result of several hard-fought judicial and regulatory battles. For a recap, see page 22; for commentary, see page 6.

On the Cover
Cover art by Doug Waltz, Spectracomp, Mechanicsburg. Original photos courtesy of the Archives and Special Collections on Women in Medicine, Medical College of Pennsylvania, Philadelphia. Pictured (top left to bottom right) are: Ann Preston, MD, first woman dean of the Woman's Medical College of Pennsylvania (circa 1866); Vida Erlanger, MD, with female patient (circa 1915); Gladys Taylor McGarey, MD, examining newborn baby, (circa 1945); and Carol Rose, MD, Pittsburgh anesthesiologist and State Society trustee, shown in scrubs and in the operating room (current).

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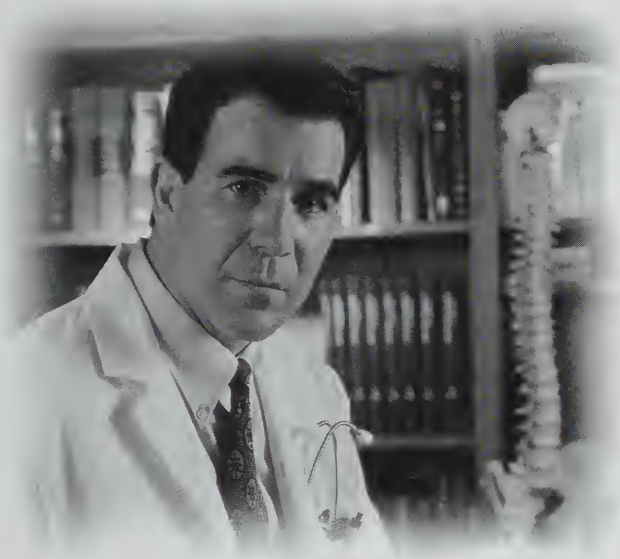

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MEDIGRAM

NEW LAW REQUIRES MEDICAL EVALUATION OF SOME MA RECIPIENTS: Physicians who treat Medical Assistance (MA) patients should be aware of a new state law adopted in June that will cut benefits for about 29,000 people—45 to 65 years old—unless they can prove they have a serious mental or physical handicap that prevents them from working. To be eligible for assistance, a patient and his or her physician must fill out a "Medical Assessment Form," stating limits to the kind of work recipients can perform. Specific instructions are included on the form; direct further questions to the MA provider hotline, (800) 537-8862.

SUPPORT FOR PATIENT PROTECTION ACT REITERATED: The Society on August 29 agreed to participate in a coalition letter to U.S. senators reiterating support for Senate Bill 2196, the Patient Protection Act. State medical societies were asked to join more than 60 patient advocacy groups strongly urging support of the bill, which addresses issues of patient choice, physician selection, and utilization review. The Senate is expected to resume reform discussions mid-month.

SOCIETY PRESIDENT TESTIFIES ON ANY WILLING PROVIDER ISSUE: Society President Martin A. Murcek, MD, testified on the "any willing provider" issue at a joint hearing of the House Insurance Committee and the Senate Public Health and Welfare Committee on August 23 in Pittsburgh. "At the heart of this issue is the question of the fundamental right of patients to have a voice in choosing who keeps them well and who treats their illnesses," he said. "At the same time, efforts to reduce costs to the health care bottom line are coming more and more into conflict with patient interests." He added, "Instead of extreme solutions, we should build on the points upon which everyone can agree"—access, quality, and freedom of choice. Dr. Murcek offered the Society's assistance to work to reach a compromise.

COMMENTS ON WORKERS' COMP REGS REFLECT MEMBER CONCERNS: The majority of Society comments sent in August to the Department of Labor and Industry on regulations proposed to implement the medical cost containment provisions of the Workers' Compensation Act of 1993 reflect physician reports of actions by insurers to delay, reduce, or deny payment for services already provided to injured workers covered under the act. Generally, the Society supports the draft regulations, which are the result of ongoing dialogue between the Society, other provider groups, and the department. However, it will continue to work with other provider groups as the department reviews comments received and determines whether to incorporate them into the regulations.

FORUM AT ANNUAL MEETING TO FOCUS ON MANAGED CARE ISSUES: In conjunction with the 1994 annual meeting of its House of Delegates, the State Society will present a special forum on the movement to managed care, capitation, and risk sharing. The annual meeting will be held October 21-23 at the Hershey Lodge and Convention Center. The forum, scheduled from 4:30 to 5:30 p.m. on October 21, will include a short program, followed by a question-and-answer session.

HMSS TO HOLD TWENTY-FIRST ASSEMBLY: The Society's Hospital Medical Staff Section will hold its Twenty-First Assembly Meeting from 9:00 a.m. to 12:30 p.m. on October 20 in Hershey. The morning session will include section business and an open forum; an optional seminar on building effective coalitions is scheduled in the afternoon. For information or to register, call (800) 228-7823, ext. 457 or 461.

AMA OFFERS TOLL-FREE HOTLINE ON REFORM: The AMA has created a toll-free hotline offering physicians daily updates on the status of health system reform in Congress. Callers will hear a message describing floor activity and its impact on organized medicine. Also, physicians will be encouraged to contact their senators and representatives to seek support for organized medicine. To access the hotline, call (800) 833-6354.

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The Tangibles of Membership

John W. Mills, MD
Medical Editor

By now you've probably read about the string of major league victories for Pennsylvania physicians which our State Society and the AMA recently won. In the aggregate, they amount to a savings to Pennsylvania physicians of more than $30 million.

They are:

• *The clinical laboratory overpayment issue,* argued successfully by the AMA/State Society legal counsel: The ruling agrees with our contention that federal law requires that if an error is made by the carrier (Pennsylvania Blue Shield in this case) and physicians are not "at fault," the physicians need not repay overpayments. To Pennsylvania physicians, **victory is worth $1.3 million, in addition to $3 million** the Health Care Financing Administration (HCFA) had already agreed to forego in earlier discussions.

• *State Society v. Snider, secretary of the Department of Public Welfare (DPW):* Compels DPW and HCFA to pay coinsurance deductibles for low-income elderly who are eligible for both Medicare and Medicaid. This decision overturns a November opinion in Federal District Court, and is similar to a federal appellate court ruling in a New York state case. **Victory is worth $25-$45 million annually** to Pennsylvania physicians.

• *Boettcher v. King:* The state Supreme Court ruled that the Catastrophe Loss Fund (CAT Fund) must pay post-judgment interest on its portion of judments not paid promptly. The State Society had argued in an *amicus* brief that physicians should not be responsible for the interest. **Victory is protection of physicians' assets.**

Thus, after a long "dry spell," Pennsylvania physicians have reason to rejoice in their membership in the AMA and the State Society. There *is* strength in numbers. Consolidating our front is sure to make an impact in health system reform and other issues facing our profession.

Couple these victories with your Board of Trustees' decision at its recent retreat, and we should have an even more effective organization. The board approved a plan to begin changing the Society from a "member-driven" organization into a "member*ship*-driven" organization (see page 38).

The single most important factor in a successful organization of any type is the input of the members, followed closely by how that input is used by the organizational hierarchy. Obviously, output from the organization has to be effectively disseminated to the members. This is, then, in simple terms, a real two-way informational highway.

While the board unanimously supports the "membership-driven process" concept, we are studying ways to get members—YOU—to become a more effective force on the two-way informational highway.

Look at the basics: You assimilate the information we send to you by mail, fax, phone, or computer—either read it or hear it. Then, after your integrated thought process, you must communicate your opinions, reactions, evaluations, concerns, and critiques to us, via mail, phone, fax, or computer. We in turn respond to you, and the process goes on.

We accept the responsibility for building this highway—a lot of work on our part. But work is also involved on *your* part, and unless you are willing to do that work, we will not have a successful membership-driven Society.

The other major outcome of our retreat was to seriously consider the makeup of our organization—councils, commissions, task forces, departments, etc.—and our House of Delegates' representation in relation to geographic concerns and physician numbers. We need to address these issues with sincerity and careful thought in order to make our whole Society more effective for the twenty-first century.

You will be hearing about all of this very soon—and I ask your indulgence *and input* as we try to assemble a more effective—more tangible—state medical society. Remember, the membership-driven process yields benefits; but we need all of you to help keep us focused and working in concert. Let's avoid "self" and personal agendas.

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The List Is Long Indeed

Martin A. Murcek, MD

One of the things that Representative Fortney "Pete" Stark (D-CA), the most physician-friendly member of Congress, likes to say is that the AMA doesn't represent the majority of physicians in America. Unfortunately, by a slim margin, he's right. Only 42 percent of the nation's physicians are AMA members.

Of course, those who are not members benefit from much of the work the AMA does. Though they may disagree with some of the AMA's positions on particular matters, make no mistake, they have benefited from initiatives and lobbying funded by the AMA membership.

Around the state, I've heard from some physicians who are opposed to what is commonly called "unification," or—I prefer this designation—the Federation. The Federation is the combination of your county medical society, the Pennsylvania Medical Society, and the AMA all working in concert to represent the interests of physicians locally, across the state, and across the nation.

There is a faction in some areas of the commonwealth that opposes unification. A variety of reasons are given—some valid, some not.

Many physicians say that the combined county, state, and AMA dues are simply too much, especially for a young physician just starting out with perhaps a huge amount of debt related to tuition loans. I can't dismiss that argument out of hand, but I urge you to look at it as more than just a "money matter."

Those who believe deunification would help bring back lost members for their county societies are simply mistaken. At the State Society board's retreat in July, guest speaker Henry L. Ernstthal noted that the percentage of "joiners" in society as a whole is down. The fact is, fewer people join organizations nowadays. Trying to recarve the pie won't change the fact that it is a smaller pie today.

Nonetheless, those who have joined and supported the AMA have played a key role in keeping the physician's voice heard in the health system reform debate. Despite the Clintons' wishes that if ignored, the AMA would go away, the biggest force in organized medicine continued to make sure that American physicians' interests were not swept aside by Hillary Rodham Clinton's "secret council."

"Those who believe deunification would help bring back lost members for their county societies are simply mistaken."

When a physician asks me, "What does the AMA do for me?" I have to respond, "How much time do you have?" There's a big risk I might overlook something important, because the list of things the AMA is doing for physicians is long indeed.

As to the assertion that the AMA is "too distant," I can only respond, "How much clout does your county society have with the California congressional delegation?"

In truth, the AMA is only as distant as your nearest state delegate, and there are 24 delegates and 24 alternates in Pennsylvania.

I've devoted most of my time in organized medicine to the State Society and to my specialty societies, but during my year as president, I've gotten a better understanding of what the AMA is doing for *all* doctors across the state.

I can't urge you enough to support the Federation. You do get a lot of value for all those dues.

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LETTERS TO THE EDITOR

DISPUTE SPARKS FINAL COMMENTS

In their exchange of letters regarding the HCFA "Single Statewide Charge Class" conflict [PENNSYLVANIA MEDICINE, June 1994], Drs. William Frankl and John Mills probed how best to unify the Society. As painful—and, some would say, unnecessary—as was this process, it provided lessons to be re-learned by *all* physicians (and not just Society leaders):

1) *Motivated* people can act effectively from their own perspectives.

2) It's folly to adopt a position which overtly benefits one subset of the membership at the *expense* of another.

3) It's unwise to adopt a policy which clearly has financial underpinnings; sometimes, it's best *not* to act.

4) It's risky to allow the House to shout-down a delegate (myself) who (correctly) notes a deviation from proper parliamentary procedure, and then not to rectify the error (here, the need to *vote* whether to hold a secret ballot).

5) One aspect of the Society's structure requires restudy: To Dr. Mills, "The House of Delegates is responsible only to their county constituencies." This consideration must be *relegated* below the need to "continually reflect on its responsibility to...all Pennsylvania physicians."

Dr. Frankl's letter was unanimously endorsed by the Philadelphia County Medical Society board (at my behest) because (in my judgment) we feel that this event (and its causes) must be put behind us, ASAP. There are already *enough* external threats to our medical professionalism which require ongoing diagnostic/therapeutic "management." There mustn't be divisiveness within the House of Medicine!

Robert B. Sklaroff, MD
Member, State Society House of Delegates
Member, PCMS Board of Directors

SEN. DOLE'S REFORM BILL SUPPORTED IN PHILADELPHIA

Editor's Note: This letter was delivered via telegram to Senator Robert Dole (R-KS) on July 31, 1994. The author forwarded a copy to PENNSYLVANIA MEDICINE in an effort to share his thoughts with his colleagues statewide.

Dear Senator Dole:

I've been a long-time supporter of yours. Now, you have assumed the role of savior of the American medical structure.

The bill you have introduced on health care change is excellent! The Clinton, Gephardt, and related approaches are disastrous. There can be no compromise between your approach and theirs. They advocate employer mandates, so-called universal coverage, massive tax increases, massive federal intervention and penalties, decline in quality of medical care, and rationing, among other undesirable features. There can be no compromise with these. The American people and the health professions are hoping and praying you will give leadership to your health program and will defeat the Clinton, Gephardt, and related bills as they should be.

Respectfully and with admiration,
Paul S. Friedman, MD
Past President
Philadelphia County Medical Society

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Remember—comments do not have to be negative! What has your county or State Society, or the AMA, done for you lately that you *approve* of? **See this issue's editorial on page 6 for more reasons why we need to hear from you.** Please send letters to:

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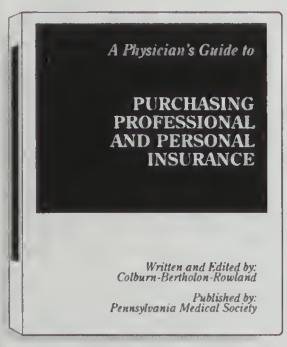

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Things Are Looking Up

Maria T. Montesano
Assistant Managing Editor

This month, the State Society along with the AMA is celebrating Women in Medicine Month and the theme, "Women Physicians on the Move," which recognizes the increasing number of women physicians in leadership positions. In this article, we talk with three of those women, who agree that "things are looking up" for them, their female colleagues, and future women in medicine.

No one really wants to admit that "women in medicine" is an issue; yet, women physicians from across the commonwealth can't seem to deny it either. Statistics and experience show inequities for women physicians in pay, advancement, family responsibilities, and most importantly, respect from colleagues. But the good news is that change is being noticed by many, and the future is sure to be brighter for all.

Women physicians now comprise close to 20 percent of all U.S. physicians and nearly 40 percent of all medical students, according to the AMA. Those numbers are consistent in Pennsylvania, and, in fact, the Medical College of Pennsylvania, Philadelphia, is one of only 10 medical schools nationwide with more than 50 percent women already. That trend is not expected nationwide until well into the next century.

Yet, while the numbers increase (see chart, next page), a 1993 study shows that more than 50 percent of women physicians still experience regular gender discrimination.[1] So, we ask, Is 'women in medicine' an issue or not?

Experience is key

Carol E. Rose, MD, a Pittsburgh anesthesiologist and member of the State Society's Board of Trustees, says she never used to think "women in medicine" was an issue. "I don't act or say things because I'm a woman, or at least I don't think I do. In return, I like to think that my colleagues and patients respond to me as a physician and not a woman...I've always thought of myself as a physician who happens to be a woman."

Dr. Rose says it's only recently that she's become aware of being treated or responded to differently because of being a woman. She relays two specific experiences.

"With the first case, I wanted to discuss a situation with a surgeon regarding his treatment of a patient," Dr. Rose says. "I was quite upset, and he responded by walking away from me, saying 'I can see that you're upset; we'll finish this conversation when you've calmed down.' But I insisted that we talk about the issue; and we also talked about he fact that he walked away from me. He said that was what he does when his wife gets upset—he just walks away from her. In other words, he was reacting to me as a woman and not as a physician colleague. Boy, did that hit me right between the eyes."

The second experience occurred in the operating room, she says. "I asked a surgeon not to approach the patient until I had taken care of certain monitoring equipment, and he ignored my request. I said, 'Doctor, I asked you not to do that, and I really meant it.' After the case was over, he came over, put his hands on his hips, and said, 'Sweetie, nobody's ever spoken to me like that before...especially not somebody who is as junior as you are.' Since my hair was covered, he

didn't see my gray hair. So I turned to him and put my hands on my hips and said, 'To start out with, I'm not your sweetie.' I then went on to discuss the rest of it with him. He seemed shocked."

One step forward

Dr. Rose says she was quite distressed by those events. "It occurred to me that I have been ignoring this for years—ignoring the woman in me as far as being a physician, and I decided it was time to do something about it." The mentoring program for women medical students of the University of Pittsburgh, with which she was already involved, has now taken on even greater importance for her.

"The program is intentionally unstructured." She explains, "We agree to be there when the students need us; and occasionally, the women faculty in my department will get together with our medical students and have group talk sessions where we all share our experiences." More importantly, she adds, they also share solutions.

"I thought it would be nice to have an association with medical students, and medical students who happen to be women was perhaps a second issue," she says. "I've gotten very, very positive feedback from the women medical students who really seem to feel that there is a need for this program, so obviously 'women in medicine' is an issue to them, even if it hasn't been an issue for me until recently."

The status achieved by male versus female physicians has remained an issue throughout the years. The AMA has said part of the reason women physicians do not achieve the same status as men physicians is because women lack mentors and peer networks,[2] but Dr. Rose says it's obvious that programs such as the one at the Pitt are a step forward.

Medicine's effort

Another step is that being made by organized medicine. "When I first became active in the State Society and attended my first House of Delegates meeting," Dr. Rose says, "there was no question in my mind that it was an 'old boys' club,' as many have asserted, especially in the handling of issues. I must say, however, that I never was treated as being a women first and then a member of the delegation. I always received full respect and consideration. So, I do believe that there was an element of 'the old boys club' back then, but I think it's very different now."

Robin Scheiner, MD, a 33-year-old dermatologist from Drexel Hill and West Grove, agrees, admitting that the perception of organized medicine as an "old boys' club" still exists, although maybe not as much as when she first joined.

"The first year I got out in practice," she says, "I tried to pursue a position on the board of the Delaware County Medical Society, and for the longest time, nobody ever got back to me." At that time it was an all-male board. But, Dr. Scheiner remained "persistant without being obnoxious," and eventually her efforts paid off—she currently serves as one of two female board members of the county society.

"I try to encourage other women physicians to get involved in organized medicine as well, although time committment is always a factor," she adds. "At this point in time, with all the political changes that are going on, *all* physicians should be involved in organized medicine. One of the best ways to influence current legislation is to be in an organized group speaking with one voice."

With that in mind, Dr. Scheiner says she doesn't like to see women in medicine made into an issue. "As I said, I really think it is important for doctors to act as one unit, and I don't like groups that try to section themselves off among physicians either."

Dr. Scheiner considers herself "lucky," having come into medicine, she says, at a time when there are more women physicians, and a lot less discrimination and harassment. "I can think of one episode of sexual harassment in my entire training...Considering all the training I've had, one episode isn't really that bad."

As for women who choose her as a physician because she is a woman, Dr. Scheiner says, "I believe that is human nature, not a form of reverse discrimination." She explains, "Some female patients seek out female physicians for certain problems. The corollary, of course, is some men with certain problems may feel uncomfortable with a woman physician."

"I don't feel badly about that," Dr. Scheiner adds. "I certainly don't want a patient to feel embarrassed or uncomfortable. Patients should see whatever doctor they feel most comfortable with. I mean, there are Italian patients who seek out Italian doctors because they speak the language...."

For Dr. Scheiner, the gender difference comes more in her private life—balancing child care and her personal life with her profession, she says. But, that too seems to be changing, according to Dr. Rose. "I think women are still handling the traditional mothering aspects of family life, although I do see more of my male colleagues concerned with child care and other parenting issues."

The importance of diversity

Dr. Rose attributes many of the changes—especially within organized medicine—not to the greater number of women physicians, but more to "the young people who have been taught the importance of diversity."

In fact, recognizing the importance of a diversified workplace and diversified population is the key to change,

Percentage of U.S. Physicians Who Are Women

1970	7.6
1980	11.6
1990	16.9
1993	19
2010	29.4*

** AMA projection*

The Numbers Are Growing

According to the Association of American Medical Colleges, 17,957 women applied to medical school in 1993, compared with 10,411 in 1987.

according to Roberta L. Schneider, MD, a Doylestown resident and vice president of Novo Nordisk Pharmaceuticals of Princeton, New Jersey.

Dr. Schneider says, "There is this piece of me that would like to say that 'women in medicine' is not an issue, but I still believe that it is." She talks of instances in her training where women "had to be very aggressive" to get an opportunity to perform certain procedures and certain types of examinations. Now, she believes women physicians need to be more aggressive in facilitating change. "I don't think the discrimination is mean spirited," she says. "It's just that a lot of women are not calling attention to episodes of sexism or genderism, so men don't even see if they're doing it [and] they don't have a chance to make progress."

"The culture of industry has changed a lot faster...not because the people wanted it to, but because the government told them it had to change. Government told businesses they had to put people in certain positions and implement certain training programs...So they were forced into doing it. Once the force came, and once people started to recognize the value to having a diversified workplace and diversified population, then it was self-perpetuating. That hasn't happened in medicine yet; it's going to take some time, but it's desperately needed."

A brighter future for all

As for the future, these women agree that a change for the better has begun. Dr. Rose summarizes, "If anything, the future will be brighter for women physicians. In managed care, we're going to see a closer approximation of the 40-hour work week. Once we're there, it doesn't matter whether you're male or female, whether you're a physician or a secretary or a nurse. When you have a more reasonable lifestyle, it's easier to handle whatever it is you've chosen to do, easier to schedule your life. In that regard, it will be easier for all physicians to lead a more 'normal' life."

It might also be easier if women physicians use their experiences to prepare themselves for the possibility of experiences like that, Dr. Rose says. "Any person in any kind of a minority situation needs to be prepared for some kind of bigoted remarks made towards them. And they have to decide in advance how they're going to handle it. Are they going to be strong, or are they going to be angry? Are they going to be vindictive, or just handle the situations with dignity?"

"Time may not heal the wrongs that were done in the past," she concludes, "but perhaps it will prepare women for handling them better and keep them from happening again. The effort needs to come from everyone."

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NIH Program Addresses Women's Health Issues

The National Institutes of Health (NIH) in 1991 established the Women's Health Initiative to study many of the important issues surrounding women's health. NIH anticipates 163,000 post-menopausal women between the ages of 50 and 79 will participate nationwide over 15 years of the study.

"Years ago, there was a great deal of concern about doing research on women because of their ability to bear children," says Loretta P. Finnegan, MD, a Pennsylvania native and director of the initiative. "I don't think it was done purposely to exclude women; it was more a safety issue. If women were in these studies and they got pregnant, there was concern that the fetus would be damaged. Then, after they had children, it was thought it would be difficult for the women to enter the study, from a practical standpoint."

The problem is that women are different physically, with different hormones and different reactions. "Fortunately," Dr. Finnegan says, "NIH has initiated the type of studies in women that have been traditionally done only with men."

Approximately 40 centers—16 already established, including one at the University of Pittsburgh, and about 24 more throughout the U.S. to be announced later this month—will study "the benefits and risks of preventive approaches and the means of achieving successful adoption of these behaviors," NIH says.

The clinical trial component enrolling 63,000 women has three interventions, and women can enroll in one or more of the intervention components. The first will evaluate the effect of a low-fat dietary pattern on prevention of breast and colon cancer and coronary heart disease. The second will examine the effect of hormonal replacement therapy on prevention of coronary heart disease and osteoporotic fractures. The third will evaluate the effect of calcium and vitamin D supplementation on prevention of osteoporotic fractures and cancer.

A concurrent long-term observational study of 100,000 women will delineate new risk factors and biological markers for disease in women. NIH expects the initiative to be completed in 2005, with results due in 2007. Its investment is expected to reach almost $628 million.

For more information on the Women's Health Initiative, call (301) 402-2900; or in Pittsburgh, call (412) 624-6926. For more on women's health and medical education, see pages 18-19.

GEISINGER CLINIC

1994-1995 Continuing Education Programs

Primary Care Orthopaedics
Wednesday
September 21, 1994

Depression Seminar
Friday
September 23, 1994

New Developments in Anesthesia
Saturday
September 24, 1994
Lancaster Host Resort

Annual Cardiology Seminar
Wednesday
September 28, 1994

Update in Neurology
Thursday
September 29, 1994

Update in OB/GYN
Wednesday
October 5, 1994

Diabetes/Endocrinology Update '94
Wednesday
October 19, 1994
Danville Days Inn

Women's Health Care Issues
Wednesday
November 2, 1994

8th Annual Horizons in Cardiac Rehabilitation
Thursday
November 3, 1994
Danville Days Inn

Advanced Cardiac Life Support Instructor Course
Friday & Saturday
November 4 & 5, 1994

Vascular Disease for the Primary Care Physician
Wednesday
November 9, 1994

Update in Pediatrics
Thursday
November 17, 1994

2nd Annual Emergency Medicine Seminar
Friday-Sunday
November 18-20, 1994
Outer Banks, NC

Advanced Trauma Life Support Provider Courses (ATLS)
Friday & Saturday
January 20 & 21, 1995
OR
March 10 & 11, 1995

Advanced Cardiac Life Support Renewal Course
Wednesday
February 1, 1995
OR
Wednesday
March 15, 1995
OR
Wednesday
May 10, 1995

20th Annual Concepts in Clinical Practice Course
Friday-Sunday
February 10-12, 1995
Danville Days Inn

Contemporary Issues in Internal Medicine
Wednesday
March 8, 1995

Cutaneous Surgery
Friday
March 17, 1995

Advances in Dermatology
Wednesday
April 5, 1995

Annual Thoracic Medicine Seminar
Wednesday
April 19, 1995

Primary Supportive Care for the Cancer Patient
Friday
April 28, 1995

9th Annual Sight Loss Support Group Meeting
Wednesday
May 3, 1995
Danville Days Inn

Acute Renal Failure
Wednesday
May 17, 1995

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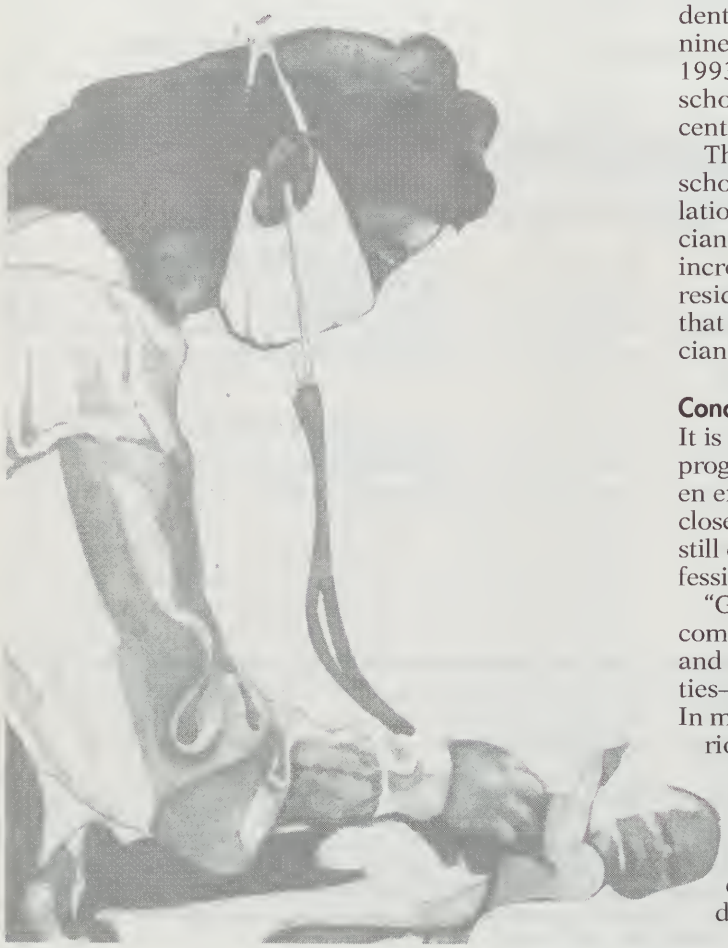
As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, Geisinger designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, at 1-800-272-6692. There is a 24-hour answering service available. You may also write to her at 100 North Academy Avenue, Danville, PA 17822-1350.

Women Physicians on the Move

Phyllis Kopriva



The American Medical Association designates each September as Women in Medicine Month—a time to celebrate the achievements of women physicians and to promote the increasing opportunities for women in organized medicine and the profession. This year, the theme of the campaign is, "Women Physicians On the Move," reflecting the dramatic growth of women physicians in both number and influence. Today, 20 percent of all U.S. physicians are female—4.5 times more than in 1970.

There is a good chance now that the physician with whom you are working—in your practice, hospital, and medical society—is a woman. But it's not just their numbers that are impressive. Women physicians have taken on important leadership roles in the profession and in their medical organizations. Women now are represented in all medical specialties and practice settings, and they have made significant contributions in government, medical research, health policy, and public health.

But it has been a long, slow road for women who wanted to become physicians. Despite some initial success at the end of the last century—when the Victorian principles of the day were influencing women to look for women physicians—by the turn of the century, women represented only six percent of the physician population. In 1910, more than half of U.S. medical schools refused to accept women. Even in the 1960s women still faced some quotas in admission criteria.

The largest increase in the number of female medical students occurred in the 1970s, when women increased from nine percent to 28 percent of total applicants. For the 1992-1993 year, the number of women applying to medical schools grew to 42 percent of the total, representing a 63 percent increase since 1979.

This growth in the number of women entering medical school has carried over, of course, into the physician population. Between 1970 and 1980, the number of total physicians more than doubled; between 1980-1990, the number increased nearly 92 percent. The proportion of women in residency programs is now more than 30 percent, a figure that the AMA projects will apply to the total female physician population by the year 2010.

Concerns remain

It is obvious that women physicians have made tremendous progress in the profession, and the future is bright for women entering medicine now and in the future. Nevertheless, a closer look at women in medicine today reveals that barriers still exist that may prevent them from following certain professional paths or from moving totally into the mainstream.

"Glass ceilings," an institutional lack of flexibility in accommodating family responsibilities, sexual discrimination and harassment, inequities in pay and career opportunities—these are issues of concern to all women professionals. In medicine, however, with its long and intense training periods that usually occur during a woman's primary childbearing years, maternity leave and child care issues take on particular significance.

It is also noted that the practice characteristics of women physicians continue to differ from their male colleagues in several key areas that may be related to gender bias. Women are over-represented in the primary

care specialties. For example, women are about three times as likely as men to be pediatricians and less than half as likely to be surgeons. Lack of mentors and role models have discouraged some women from entering the non-primary care fields.

Specialty diversification among women is beginning to occur, however. In 1970, only seven specialties had more than 1,000 women physicians, representing over half of all female physicians. But by 1992, fifteen specialties had more than 1,000 women, almost 68 percent of women physicians.

Women physicians are younger on the average and, therefore, newer in practice. Statistics imply they work fewer hours and see fewer patients; however, it is unclear of the significance of that data. Some have speculated that women spend more time with their patients, thus seeing fewer in number. Women physicians are less likely than male physicians to be self-employed and twice as likely to be employees. These factors are part of the reason that incomes of women physicians average about 63 percent of male physicians' annual net income—although the income growth rate for females is higher than for men. Not all of the pay gap can be explained this way, however. Even when specialty choice and practice characteristics are factored in, the gap remains, indicating that some degree of gender-based discrimination plays a role in the generally lower incomes of women physicians.

Other inequities also exist. Academia has few women at the top. Only two of the nation's 126 medical school deans are women, and few women faculty members are full professors or department heads. Women students and physicians still complain of sexual harassment and sexist behavior. An AMA opinion poll last year brought in responses from 2,500 women in medicine, 75 percent of whom said that they had experienced sexual harassment. AMA surveys also show that, while having children during medical training practice is now commonplace, it is not made easier by murky and often inflexible organizational policies and pressures from colleagues or supervisors.

As the number of women physicians grows, and as women continue to move into the mainstream of medical practice, these gender-based practice differences will continue to diminish. And there is other good news. Women physicians have taken control of their careers and are successfully combining childbearing and childrearing, medical practice, and their professional responsibilities.

Their influence on the profession, organized medicine, and health care delivery will continue to expand. Professional benefits will probably evolve to more innovative work options, a more creative approach to maternity leave and child care issues, and perhaps a turn toward a less stressful professional environment, offering male and female opportunities to achieve a greater personal and professional balance.

Women physicians are also greatly involved in the national debate on health system reform. As medical society leaders, they are participating in the local, state, and national debate. Women appear to place a strong emphasis on public health and access issues which may shape their contributions to the debate to the benefit of their patients. Also, their primary care orientation may work to their advantage under reform.

Gender disparity

At the 1993 AMA Annual Meeting, the House of Delegates adopted a report on "Gender Discrimination in the Medical Profession," which states that "although there has been progress in recent years, women in medicine are not generally advancing to the highest levels of the profession, and are continuing to encounter subtle and overt forms of discrimination during their training and careers." The report addressed a number of gender-disparity issues, including the gap in income levels, lack of advancement in academic medicine, inadequate representation in medical research, insufficient accommodation of pregnancy and family, sexual discrimination and harassment, the lack of mentorship from women, and the ongoing exclusion of women from peer networks.

The report's 10 recommendations suggested ways to address these issues to benefit women in medicine and the profession as a whole, concluding the "profession of medicine needs talented and committed physicians and researchers, and cannot afford to discourage valuable members. Medicine's future will be greatly influenced by the presence of women, and its future success may depend on a fair inclusion and accommodation of both genders in the medical workplace."

The same can be said of organized medicine. Women traditionally have joined organized medicine in proportionately lower numbers then have male physicians. Their stated reasons include financial considerations, the "good old boy" image of the medical society, and lack of time during the years when family responsibilities are of prime importance.

Organized medicine has become more sensitive to these issues, working to better represent the interests and address the needs of its women members. The AMA's policies on sexual harassment, maternity and paternity leave, child care, and gender-neutral language demonstrate a commitment and responsiveness to women in medicine issues. More women are participating, and more are moving into important leadership positions.

The AMA Advisory Panel on Women Physician Issues serves as an advocate for women physicians and medical students. Two women hold elected positions on the AMA Board of Trustees, and many more serve open AMA councils and committees. The percent of women in the AMA House of Delegates has increased from 2.7 percent 10 years ago to over 10 percent in 1994.

The key to synergy among all physicians is to create an environment where gender differences not only strengthen the profession and organized medicine, but also enhance the art and science of medicine.

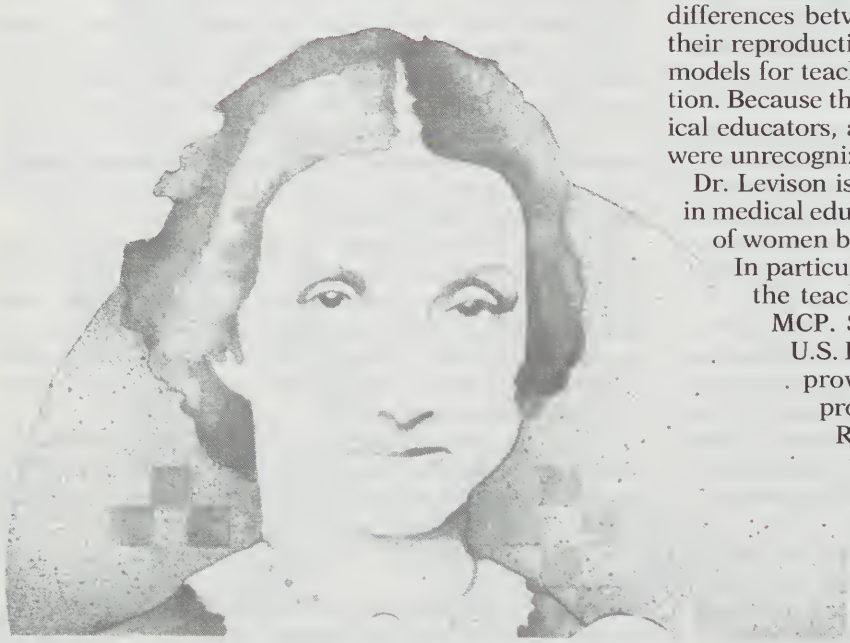
"Their influence on the profession, organized medicine, and health care delivery will continue to expand."

Ms. Kopriva is the American Medical Association's director of women and minority services.

Women's Health and Medical Education: Seeking Balance

The Medical College of Pennsylvania—founded in 1850 as the first medical school for women—is carrying out a pioneering program to improve health care to women by integrating women's health into medical education.

Eryn Dobeck



Leaf through a typical medical textbook, and look at the illustrations. How many depict men, how many depict women? For generations, male anatomy has been the norm, with females seen only in chapters on reproduction.

Last year, Kat Mendelsohn, from the Medical College of Pennsylvania's (MCP's) class of '96, noticed this bias toward using men, in both anatomy text illustrations and as the subjects of medical cases used in their problem-based learning groups. Her concern led her to participate in a research project, under the guidance of two faculty members, Sandra P. Levison, MD, and Linda Z. Nieman, PhD.

The researchers examined over 4,000 illustrations in 12 anatomy and physical diagnosis textbooks currently used at the college and other Philadelphia medical schools. They found that, for the anatomy texts, virtually all the illustrations of women were in sections on female reproductive systems. Most of the illustrations of other body parts were of males.

The textbook bias is a symptom of a broader problem, according to Dr. Levison, a professor of medicine, who says that medicine reflects society, and women have been valued historically for their sexual and reproductive role as mothers. They have only recently been given the right to vote and work outside the home. Our culture has valued white men, and medical education in general has been unwittingly slanted toward male models. Important areas of clinical research and pharmacology, on which treatments are based, have been conducted predominantly on male subjects, and the results do not always apply to women.

"Even laboratory animals are usually male," says Dr. Levison, who adds, "There is a lack of medical knowledge of the differences between men and women that extend beyond their reproductive systems. Women tend to be invisible as models for teaching in much of traditional medical education. Because there have been few female researchers, medical educators, and practitioners, many of these inequities were unrecognized or ignored."

Dr. Levison is the principal investigator of a new project in medical education that seeks to improve the health care of women by bringing more balance to the curriculum. In particular, women's health is being integrated into the teaching of first- and second-year students at MCP. Supported by a three-year grant from the U.S. Department of Education's Fund for the Improvement of Post-Secondary Education, the project is unique in American medical schools. Reviewers of the grant proposal called it "potentially groundbreaking" and rated it highly, expressing confidence that the program could serve as an educational model for other medical schools.

The women's health curriculum is part of a broader commitment to women's health by the college and the hospital. The

Center for Women's Health provides an array of preventive, diagnostic, and therapeutic health services, and the Institute for Women's Health is a multidisciplinary effort that encompasses educational, clinical, and research programs in women's health.

MCP is the first medical school in the U.S. to integrate women's health education into its curriculum. "'When medical schools offer any training in women's health, it's usually elective courses or occasional lectures, or nothing beyond training in obstetrics and gynecology," says Dr. Levison.

The new curriculum aims for understanding of diseases and conditions that are unique to, more prevalent among, or more serious in women. It does so by stressing an interdisciplinary approach to women's health, rather than a fragmented and specialized one. Students learn about medical conditions in which there are gender differences in symptoms, risk factors, and treatments. There also is a strong orientation toward community medicine and maintaining good health.

The first students to encounter the new curriculum are the 46 students in the Program for Integrated Learning (PIL), the college's alternative curriculum track for first- and second-year students. In that program, students work in small groups with a faculty facilitator to analyze patient cases and identify areas where learning is needed.

Faculty members—directed by Drs. Levison and Nieman, as well as Barbara A. Caruso, RN, PhD, of the Office of Medical Education—are authoring and rewriting teaching cases to provide more gender balance in the types of problems presented. Guided by faculty members, students learn what questions to ask female patients so they can recognize problems more common in women, such as physical or sexual abuse and eating disorders. Students learn how medical problems in a woman may have different symptoms from a man with the same condition. For instance, a woman with a heart condition may complain of dizziness or gastrointestinal distress, while a man more typically has chest pain.

"Because PIL is an integrated, collaborative program," says Charles D. Puglia, PhD, PIL director, "it means that when an area like women's health is identified, we have enough faculty, with diverse expertise, to enable us to incorporate new information into cases and provide appropriate levels of learning resource support. The PIL curriculum track is designed to be flexible, so we can revise material as new learning needs arise."

"There is a lack of medical knowledge of the differences between men and women that extend beyond their reproductive systems. Women tend to be invisible as models for teaching in much of traditional medical education."

–Sandra P. Levison, MD

The women's health curriculum sometimes asks students to analyze unexamined assumptions in their education. One tool the program has developed is a guide to gender-free bias in communication. In addition, says Dr. Levison, "We'll teach students to be sensitive to communication skills they'll need as physicians, such as in taking medical histories from a patient of the opposite sex. Improved communication between physicians and patients helps empower patients to participate in their own diagnosis, treatment, and health maintenance."

Lucia Weiss, women's health program manager, adds, "We are not teaching women's health at the expense of men. The recognition of gender differences in communication, diagnosis, and treatment will improve health care for all patients. In addition, issues of diversity account for different needs in women from various ethnic, racial, and economic backgrounds."

All PIL students participate in a primary care practicum, in which they spend nine weeks with faculty preceptors, seeing selected patients in a community setting. Some of the students may choose to do their practice in women's health projects.

Faculty development is an important aspect of the curriculum, according to Dr. Nieman, assistant dean for medical education and a co-investigator of the curriculum grant: "We're holding workshops for faculty members and developing resources on women's health, for both students and faculty. In the process, we're finding gaps in our own knowledge and learning how we can fill those gaps." Many of the same faculty members teach both PIL groups and traditional lectures, so the expectation is that PIL teachers will transfer some of the information presented during PIL groups into their lectures for students in the traditional curriculum.

"We expect this program will be a catalyst for eventually introducing formal women's health education into third- and fourth-year clinical training and residency training," says Dr. Levison. "We have already started introducing women's health teaching into the internal medicine residency, and we also are developing a catalog of women's health cases that can be used in other medical schools. Ultimately, we want our program to be a model that will help diffuse responsibility for care for women to all physicians, not just a few specialists."

Ms. Dobeck is a public relations representative, Medical College of Pennsylvania, Philadelphia.

Are YOU Ready for the Coming Revolution?

David Woods

Editor's Note: Realizing that an estimated half of all malpractice suits, and most of the questions on "report cards" on physicians, have to do with communications issues, we are launching this month a column on these issues by author David Woods, an occasional contributor to this publication. Future articles will deal with such topics as the art of listening, reading to keep up-to-date, and avoiding "medispeak."

While the term "information explosion" has already been relegated to the ranks of cliché, the issue it describes is still very much with us—there are twice as many biomedical journals as there were 15 years ago, and the clamor of other messages aimed at physicians has reached a crescendo.

With this in mind, I asked Philadelphia internist Roger Daniels, MD, to collect 10-days' worth of the printed matter that he receives in the mail. It filled a box roughly the size of a suitcase designed for far-flung travel. The trove included journals, product literature, marketing pitches, invitations, exhortations. Irresistible offers of this and that.

To be specific, there were 18 pharmaceutical product pitches, 15 journals, 12 continuing education course announcements, and a miscellany of financial, travel, software, and institutional information. It was overwhelming, and most of it was destined for transfer to another container—the trash can.

Dr. Daniels believes that three-quarters of this material is a complete waste of time. He views the pharmaceutical pitches, he says, with much the same skepticism as he would those of a used car salesman. "They have little impact" he says, noting that he gets his drug information mainly from colleagues or from *The Medical Letter*.

As for journals he actually reads? Well, the *New England Journal of Medicine* and the *Annals of Internal Medicine* rate pretty high; but, says Dr. Daniels, "I look more and more for abbreviated material...and I spend an equal amount of time these days reading about the business aspects of practice—health care reform, managed care, HMOs, etc.—whereas 20 years ago, I wouldn't have spent a minute on that topic."

Now, admittedly, this is a sample of one. Dr. Daniels' experience and attitudes may not be typical. I feel certain, therefore, that the editors of this journal would be intrigued to hear readers' accounts of *their* receivables, so far as reading matter is concerned. In any event, physicians may soon find that the cascade of communications is about to dwindle, if not to a trickle, then at least to a manageable stream.

"Physicians may soon find that the cascade of communications is about to dwindle, if not to a trickle, then at least to a manageable stream."

Consider: Pharmaceutical companies, concerned about health system reforms that emphasize cost effectiveness and "the bottom line," are slashing their promotional and advertising budgets. In 1992, they bought 62,000 medical journal advertising pages; the projected figure for 1994 is 37,000 pages. Since most publications operate on a fixed editorial/advertising ratio, it's estimated that there will be 33,000 fewer medical journal editorial pages in 1994 than there were in 1992. It also means a longer lead time for publishing new knowledge; the information will be older when it reaches you.

And the pharmaceutical sales rep—the detail person—soon won't reach you at all, except perhaps on videotape. Among 32 major companies, there's been a seven percent decline in the number of reps in the past two years—with Bristol-Myers

Squibb showing a 30 percent drop, Upjohn 20 percent, and Syntex 18 percent. Moreover, the drug companies will be increasingly more likely to take their prescription message direct to the consumer or the pharmacist than to the physician. Think about the ads for Proscar and Prozac.

Finally, those same companies are going to divert more resources into promoting themselves—a long overdue exercise since, as the *Economist* put it in a recent article on what it called the drug industry's first serious attempt to get into the health care business, that industry is "not well thought of by consumers."

And those same consumers—your patients—will be getting more information, some of it from the pharmaceutical companies, some from a growing array of health care education sources in a variety of media. According to *Harper's Index* (June 1994) the ratio of Americans citing the source of their medical information is two to one in favor of television over physicians. So be prepared to answer increasingly sophisticated questions.

And, above all, be a communicator, because another aspect of the revolution in medical communication is the "report card" that patients will fill out on their doctors. If you've seen one of these, you'll have noted that most of the questions have to do with how the doctor is perceived as a communicator rather than as a clinician.

In sum, then: Fewer pharmaceutical ad pages, therefore fewer medical journals, therefore a longer lead time in getting information to you; fewer detail folk; more 'abbreviated' reading matter, especially on management issues; a more knowledgeable and questioning health care consumer; and a greater variety of media.

As Mary K. Cowell, president of the American Medical Publishers Association, puts it: "Our association used to be all print companies; now, more and more member organizations are in purely electronic media, such as CD-ROM." She says the present cutbacks in advertising may merely be a pause while pharmaceutical companies—and other medical entities—retrench and seek out different ways of getting their message across. Perhaps physicians should be keenly aware as new styles of communications emerge around them. ⬡

David Woods

Mr. Woods, former editor and publisher of the **Canadian Medical Association Journal,** *is president of Healthcare Media International, Inc., a Philadelphia-based corporation that publishes, among other titles,* **Medical Practice Communicator,** *a newsletter on communications for physicians. He is the author of* **Paging Doctors** *and a frequent commentator on health care issues.*

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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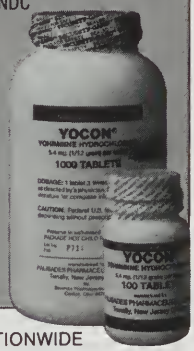
Rev. 1/85



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State Society Scores Wins for Members

By summer's end, the State Society had tallied substantial savings for Pennsylvania physicians as the result of several hard-fought judicial and regulatory battles.

Medicaid rules

The string of victories began in early July, when the Society convinced the state Department of Public Welfare (DPW) to delay implementation of the new Medicaid preauthorization program by two weeks to allow physicians time to receive and review instructions from DPW. The information—which explained new rules for how physicians are to obtain preauthorization for brand-name drugs that have a USDA "A"-rated generic substitute, and how to request exceptions—arrived in physicians' mailboxes about the same time the program was scheduled to start. The Society voiced a number of concerns about the program to DPW.

Overpayment error

A second victory came on July 19, when a Medicare fair hearing examiner in Maryland agreed with the AMA and the State Society that physicians should not be responsible for Pennsylvania Blue Shield's error in over-reimbursing for certain Medicare clinical lab procedures. The ruling and prior efforts of the AMA and Society will save Pennsylvania physicians more than $4 million.

Through intense earlier discussions by the AMA, the State Society, and other groups, the Health Care Financing (HCFA) had already agreed to forego $3 million in overpayments. The ruling—which resulted in additional savings of $1.3 million—agreed with our contention that federal law requires that if an error is made by the carrier and the physicians are not "at fault," the physicians need not repay overpayments.

The AMA had offered to represent all of the 730 affected physicians who were members of the AMA or their state medical society. Physicians from New Jersey, Delaware, Virginia, the District of Columbia, and Maryland were also represented in the appeal.

"Physicians are overwhelmed with third-party payers' myriad requirements. When physicians comply with those requirements and, after the fact, third-party payers determine the payment was in error, it undermines the credibility of the entire reimbursement process," commented James S. Todd, MD, AMA executive vice president. Blue Shield cannot repeal this ruling and was to send refunds within 30 days to physicians who joined the State Society's appeal.

Dual eligibility

Perhaps the biggest financial victory—estimated at between $25-45 million or more per year in higher payments to physicians—came with the Society's win in the federal Third Circuit Court of Appeals in late July.

The Society won its appeal in the case of *Pennsylvania Medical Society v. Snider.* The ruling compels DPW and HCFA to pay coinsurance and deductibles for low-income elderly who are eligible for both Medicare and Medicaid. The Society argued on behalf of physicians in the commonwealth that federal statues require the Medicaid program to pay these amounts, which otherwise are paid by enrollees. HCFA and DPW declined to do so, except in limited numbers of cases where the Medicaid payment would exceed the Medicare reimbursement.

The ruling overturned a November opinion by President Judge Sylvia Rambo of the Federal District Court for the Middle District of Pennsylvania who denied our motion for summary judgment. The Appeals Court ruled that the Pennsylvania limitations on payment violated both the Medicare Act and the Medicaid Act, and reversed the judgment of the District Court.

The three-judge Appeals Court panel said in its opinion "...because [low-income elderly] are poor and cannot financially shoulder the burden of paying the Medicare Part B cost-sharing...Congress required the states to stand in [their] shoes... Accordingly, Medicare Part B service providers who supply service to [low-income elderly] are entitled to recover 100 percent of the [Medicare-allowable] costs and charges."

This decision is similar to a federal appeals court ruling in a New York case, and several more cases are pending in other appeals courts. The federal government has at least 90 days, and possibly up to 150 days, in which to file a Petition for Certiorari to the U.S. Supreme Court.

CAT Fund controversy

Also in late July, in *Boettcher v. King*, the state Supreme Court ruled the Catastrophe Loss Fund (CAT Fund) is not immune from paying post-judgment interest. The case involved a plaintiff's attempt to wrest an interest payment from a physician, the Pennsylvania Medical Society Liability Insurance Company (PMSLIC), and the CAT Fund for a portion of a judgment that was not paid immediately. PMSLIC had already paid its portion of the verdict, but the CAT Fund withheld payment of its share of the judgment, claiming state law requires it to delay payments until the December 31 following the August 31 by which the judgment became final.

The fund also claimed to be statutorily exempt from paying post-judgment interest. The plaintiff appealed to Commonwealth Court, which held that the CAT Fund is not immune from paying interest on its share and that it, not the physician or insurer, is liable for the payment.

Both the plaintiff and the CAT Fund appealed to the state Supreme Court. The Society argued in an amicus brief that physicians should *not* be responsible for the interest. The court agreed that state law does not exempt the CAT Fund from paying post-judgment interest, also noting that the law calls for judgments to be paid on or before December 31.

SURGICAL PATHOLOGY CODES CHANGED

Pennsylvania Blue Shield has reduced the total charge and professional component allowances for surgical pathology procedures by 20 percent for private business plans. Blue Shield has indicated the change, which became effective on May 30,

1994, was necessitated by a modification in reporting requirements for codes 88300, 88302, 88304, 88305, 88307, and 88309.

Based on a recent decision by Blue Shield's board of directors, one surgical pathology code can now be reported for each separately identifiable specimen that requires individual examination and pathologic diagnosis. Blue Shield recommends the following guidelines for reporting surgical pathology studies:

- A specimen is defined as tissue or tissues that is (are) submitted for separate attention, requiring individual examination and pathologic diagnosis.
- Report code 88300 for any specimen that can be accurately diagnosed without microscopic examination.
- Report code 88302 when gross and microscopic examination is performed on a specimen to confirm identification and the absence of disease.
- Codes 88304-88309 represent additional ascending levels of physician work and are specifically defined by the assigned specimen. Report codes 88304-88309 for all other specimens requiring gross and microscopic examination.
- Assign any unlisted specimen to the code which most closely reflects the physician work involved when compared to other specimens assigned to that code.

As a result of this change, Private Business Blue Shield and Medicare are consistent in reporting guidelines.

Direct any questions about billing for surgical pathology services to the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

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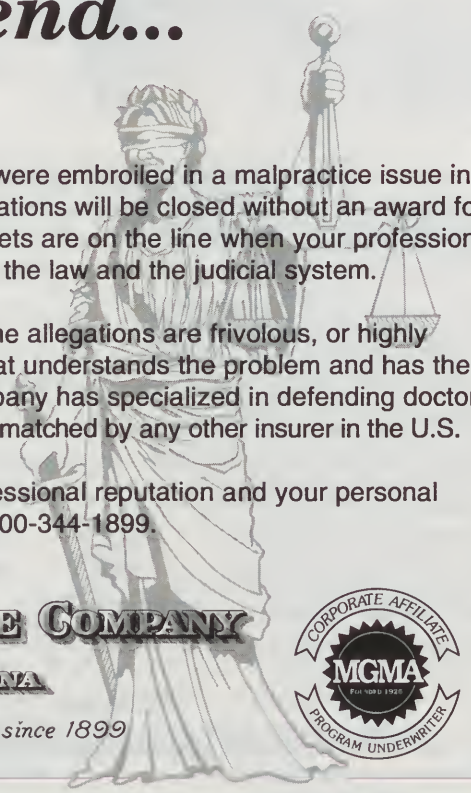

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AMA VOTES TO SUPPORT BI-PARTISAN BILL

As the health system reform debate turned vicious in Congress toward the end of summer, the AMA stepped forward in support of the House Bipartisan Plan, dubbed the Rowland-Bilirakis bill. Early newspaper reports expected the plan to shun both tax increases and employer mandates.

Only days after the U.S. Senate opened debate on reform, the AMA board called a special meeting in Chicago to analyze the bipartisan legislation. The board had already taken a position of "non-support" for the House Democratic Leadership bill. On August 10, the AMA announced its endorsement of the "bipartisan bill," pending final review of legislative language. The AMA also expressed willingness to explore all options in the U.S. Senate to find a suitable comprehensive bill meeting the AMA's health reform goals.

According to the AMA, the bipartisan bill offers all Americans and their families the most realistic hope in the House of Representatives for significant health system reform of all the bills currently under consideration. The AMA believes that the bill:

- provides health care security—allowing portability and eliminating pre-existing conditions and exclusions—almost immediately through significant insurance reforms;
- offers a substantial first step toward the goal of coverage for all Americans;
- protects and preserves the patient-physician relationship;
- avoids and protects against unnecessary and burdensome bureaucracy;
- ensures patients' choice of physicians and offers options for health insurance to patients;
- protects patients and physicians from arbitrary decision-making that puts profits before quality patient care;
- would preserve the world's finest medical education system; and
- provides significant professional liability reforms.

The board also expressed concern that the bill does not contain adequate tobacco taxes and would institute Medicare cuts that might reduce access to physician services for seniors and the disabled.

Details of the plan were sketchy at press time. Reported as "lightening rods" for any potential bipartisan compromise were Representatives J. Roy Rowland, MD (D-GA), a former family doctor; Jim Cooper (D-TN); Fred Grandy (R-IA); and Michael Bilirakis (R-FL).

Representative Rowland and nine representatives unveiled the plan on August 12, saying the plan would cover 90 percent of Americans by the year 2004. The White House denounced the bill, saying it would not control costs or help middle-class or older Americans or small business. The bill was supported by a coalition of five big insurers: Aetna, Cigna, Metropolitan Life, Prudential, and the Travelers Corporation.

As the bipartisan plan was being unveiled, debate on reform was postponed while the House Democratic leaders concentrated on passing President Clinton's hotly debated Crime Bill.

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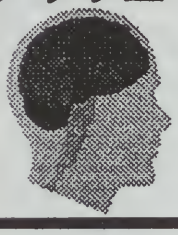

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COURSE DIRECTOR - JAMES ARGIRES, M.D.

DATE:

Wednesday
November 16, 1994

PLACE:

Lancaster
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466 New Holland Pike
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TIME:

00 - 3:30 - Registration

30 - 5:30 - Workshops

30 - 6:00 - Cocktails

00 - 7:00 - Dinner

00 - 8:30 - Lectures

30 - 9:30 - All Panel Discussion

30 - Evaluation/ Adjournment

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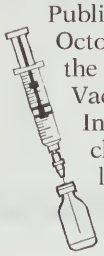

The Pennsylvania Departments of Public Welfare and Health on October 1 will begin operating the new, federally funded, Vaccines for Children program. Intended to help raise childhood immunization levels in the U.S., the program supplies—at no cost to participating providers—federally purchased vaccines for children in certain groups. Approximately 60 percent of U.S. children are expected to benefit from the program.

During 1993, the national Childhood Immunization Initiative of the U.S. Department of Health and Human Services set national goals for immunization coverage levels. Foremost is to adequately immunize at least 90 percent of the nation's two-year-olds by 1996. In support of the initiative, the Vaccines for Children program was developed.

Vaccines and combination vaccines to be offered initially will protect against nine diseases, including diphtheria, *Haemophilus influenzae* type b, hepatitis B, measles, mumps, pertussis, poliomyelitis, rubella, and tetanus. As new vaccines or additional vaccine combinations are approved by the Food and Drug Administration, and recommended by the Advisory Committee on Immunization Practices (ACIP), they will be added to the program.

The commonwealth is seeking physicians to participate in the program. To enroll, you must file a provider profile and an enrollment form with the state Department of Health stating that you agree to:

1) screen the parent or guardian to determine the child's eligibility;

2) maintain a record of the screening with the eligible child's record;

3) comply with the recommended immunization schedule as established by ACIP and state law;

4) not charge for the program-supplied vaccine (an administration fee may be charged as long as service is not denied because the fee cannot be paid); and

5) provide vaccine information materials as prescribed by law for all providers.

For more information, or to receive profile and enrollment forms, contact the immunization program office, Pennsylvania Department of Health, (717) 787-5681.

MALNUTRITION WIDESPREAD AMONG RURAL ELDERLY

Research conducted by commonwealth physicians and nutritionists has found widespread malnutrition among elderly people in rural central and northeastern Pennsylvania. The findings are the product of the four-year-old Geriatric Nutrition Research Alliance, in which physicians at Geisinger Medical Center, Danville, and academic researchers at Penn State are working together to study nutritional problems among the elderly.

Using Geisinger's resources, researchers have examined nutrition knowledge among 180 women over 65 years of age in small Pennsylvania towns. Many have limited nutrition knowledge and suffer from medical conditions, like heart disease, that have well-defined nutritional causes. Geisinger's studies also show that malnutrition is common among older people who are ill and come to the hospitals.

For more information, call Gordon Jensen, MD, PhD, at Geisinger Medical Center, (717) 271-6439.

Excerpted with permission from "Pennsylvania Rural Health News" of the Pennsylvania Office of Rural Health, Colleges of Agricultural Sciences & Health & Human Development, The Pennsylvania State University, Spring 1994.

COUNCIL UNVEILS NATIONAL ORGAN DONOR CAMPAIGN

The nationally recognized Advertising Council, the creator of "Friends Don't Let Friends Drive Drunk" and other important public awareness campaigns, has taken on the organ donor shortage through a new national campaign, "Share Your Life. Share Your Decision."

The purpose of the campaign, unveiled at Penn State's Milton S. Hershey Medical Center in July, is "to drive home the message that good intentions don't save lives; actions do," says Howard Nathan, executive director of the Delaware Valley Transplant Program.

The new campaign was produced on behalf of the Coalition on Donation, a nonprofit alliance of more than 40 hospitals, organ and tissue donor programs, eye banks, patient groups, and affiliated health organizations serving the eastern half of Pennsylvania, south New Jersey, and Delaware.

For more information, call the Coalition on Donation at (804) 330-8620 or the Advertising Council at (212) 922-1500, extension 222.

PRACTICE PARAMETERS NEWS

U.S. AGENCY RELEASES HEART FAILURE GUIDELINES

Millions of Americans now suffering from heart failure could lead longer, more active lives under new guidelines released in late June by the U.S. Public Health Service's Agency for Health Care Policy and Research.

The guidelines, which are based on the results of the latest clinical trials and outcomes research, call for wider use of medications proven capable of preventing heart failure in some high-risk patients, and improving comfort and longevity in patients with established heart failure.

Targetting left-ventricular systolic dysfunction, the most common type of heart failure, the guidelines recommend use of sophisticated imaging technologies for making initial diagnoses, while generally relying on observation of patients' symptoms and physical signs to monitor treatment progress. They also urge better patient education and compliance, and call for the use of bypass surgery or angioplasty in selected instances.

Free copies of "Heart Failure: Management of Patients with Left-Ventricular Systolic Dysfunction," the guidelines' quick reference guide for clinicians, and the patient guide, "Living with Heart Disease: Is It Heart Failure?" (available in English and Spanish), may be obtained by calling (800) 358-9295 or writing: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

Single free copies of the clinical practice guideline, "Heart Failure: Evaluation and Care of Patients with Left-Ventricular Systolic Dysfunction," also are available from the clearinghouse on a limited basis.

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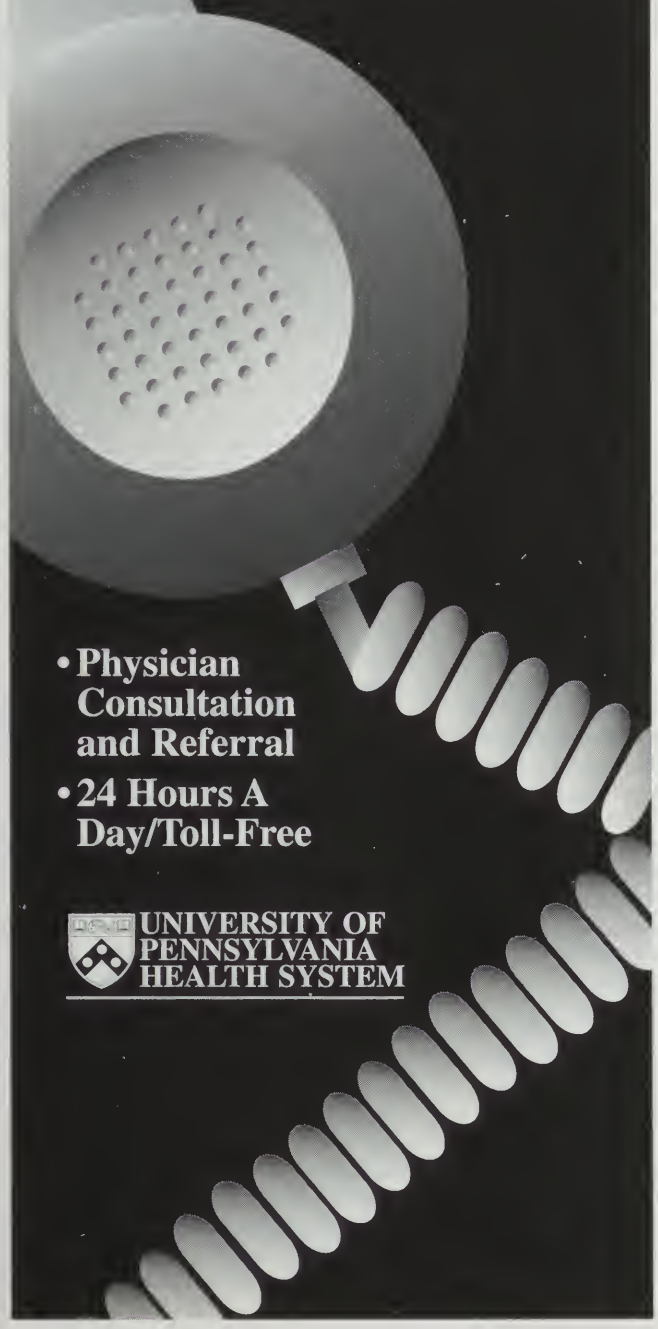

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- Carotid Artery Disease: When to Consider Endarterectomy
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AMA DELEGATION NEWS

Reform Takes Center Stage at AMA Annual Meeting

Health system reform again took center stage at the AMA House of Delegates' Annual Meeting, held June 18-22, in Chicago.

The AMA House reaffirmed several key elements of its health system reform policy during the meeting, such as achieving universal coverage through a combination of strategies and opposing a Canadian-style single-payer system. As reported in the June 27 *AMNews*, "While [the House] took steps to rein in managed care, they turned down calls to open panels to any physician who meets a plan's stated criteria."

The Pennsylvania Delegation to the AMA offered 10 resolutions at the meeting: Six were adopted; three were addressed in reports adopted in lieu of the resolutions; and one was referred to the AMA board.

The adoption of an AMA board report on violence and the media gained national media attention. The report directs the association to "urge the entertainment industry to fundamentally change its ratings system to give consumers more information about violent and sexual content."

Lee H. McCormick, MD, Allegheny County, was re-elected chair of the AMA Hospital Medical Staff Section Governing Council at the organization's annual meeting in June. Above, he and wife, Barbara, enjoy campaign activities.

A related Pennsylvania resolution proposed that the AMA "review the ways it has provided guidance to the entertainment industry, either as an organization or through its membership...and determine ways it could influence the entertainment industry regarding its depiction of violence."

The call for changes in the rating system received mixed reviews from the media—some applauded the AMA's stance, but others said the issue is not health related and not the business of the AMA. But the federation of medicine says it will remain committed to its action as part of its fight against family and societal violence, and AMA President Robert E. McAfee, MD, said he was pleased that the delegates gave their strong support to the action.

Adoption of health system reform and violence resolutions is consistent with issues of importance to Pennsylvania physicians, according to the State Society's annual Membership/Leadership Poll. The results, released in April, indicate increased concern about violence, rating it third in importance after health system reform and liability tort reform. Last year, Society members rated violence seventh in a list of 10 concerns.

Other Pennsylvania resolutions direct the AMA to:

- review, analyze, and develop a policy about the most desirable types, and the most desirable amounts, of patient cost-sharing measures, including large deductibles (e.g., medical savings accounts);
- study ways to discourage the present control of employee health insurance choices by employers, and report back to the House at the 1994 Interim Meeting;
- develop a position paper on the role of tax deductions, exemptions, and credits in health-related activities;
- review the California state anti-tobacco advertising campaign to discern whether to recommend the nationwide use thereof;
- work with state medical societies and appropriate professional specialty organizations to encourage physician participation in the Project USA physician referral network;
- study refining the Current Procedural Terminology (CPT) coding process to improve descriptive terms and codes so that they might be useful as a precise scientific database or an accurate database for physician payment; and
- request the Health Care Financing Administration to unbundle the payment for ventilator management codes from daily evaluation and management consultation codes.

Doris G. Bartuska, MD, Philadelphia County, was one of the 48-member Pennsylvania Delegation to the AMA to travel to Chicago in June for the AMA's annual meeting. She is pictured with husband, Anthony, first district counselor of the Pennsylvania Medical Society Alliance.

The Pennsylvania delegation also asked the AMA to mandate the board to prioritize all AMA activities and fund only the activities which can be afforded within projected 1995 revenue without a dues increase. An AMA board report addressing the same issues was adopted in lieu of the state's resolution.

Finally, referred for further study was a resolution asking the AMA to study and project the physician workforce to treat the age distribution anticipated in the decades 2010 to 2040.

Election results

In elections, Lee H. McCormick, MD, Pittsburgh, was re-elected chair of the AMA Hospital Medical Staff Section Governing Council, and William H. Mahood, MD, Flourtown, was re-elected to the AMA Council on Medical Service.

Jonathan E. Rhoads Jr., MD, York, was unsuccessful in his effort to obtain a seat on the AMA board.

Also at the meeting, Donald G. Ferguson, MD, the State Society's immediate past president, was elected to the board of the Organization of State Medical Association Presidents.

COUNTY NEWS

MONTGOMERY COUNTY INSTALLS 147TH PRESIDENT

Charles Cutler, MD, Merion Station, was inaugurated as the 147th president of the Montgomery County Medical Society at its annual dinner-dance, held in Norristown in June.

A graduate of Temple University Medical School, Dr. Cutler obtained his residency training from Temple University Hospital. He practices internal medicine from his office in Norristown, is on the staff of Montgomery Hospital, and is an instructor in medicine at Thomas Jefferson Hospital.

Dr. Cutler joined the Montgomery County Medical Society in 1979, chairs its Grievance Committee, serves on the Insurance Committee, and is a delegate to the State Society.

LANCASTER SOCIETY CELEBRATING 150TH YEAR

The Lancaster City and County Medical Society this year is celebrating its 150th year with a variety of promotional materials and special events:

- A celebration banner is displayed at all Lancaster Society meetings and events.
- "The History of the Lancaster City and County Medical Society" will be published in the *Bulletin of the Lancaster County Medical Society* and in *Lancaster Medicine.*
- Medical exhibits have been displayed in Lancaster city and county hospitals.
- Articles from famous people, events, and places in the medical history of the county are published in a society column in the *Lancaster New Era* twice each month.
- Physicians' offices, hospitals, and businesses are displaying a celebration poster, prepared by Paul H. Ripple, MD, a city ophthalmologist.
- A summer picnic was held in June at the birthplace of D. Hayes Agnes, MD, famous surgeon and professor of surgery at the University of Pennsylvania (1871-1891).
- "A Prolonged Labor," a skit about the beginning of the city and county society, written and produced by Herbert L. Tindall, MD, a Christiana family practitioner, will be presented at a premier and private showing to members and spouses of the city and county society at its regular meeting this month.

For further information about these and other special offerings, call the city and county medical society at (717) 393-9588.

DOCTORS, LAWYERS UNITE AT MANAGED CARE SEMINAR

Sixty-five Montgomery County physicians and lawyers attended the annual medical-legal seminar, held at Montgomery County Medical Society headquarters in Norristown in May; this year's topic was managed care. Across the street, the staff was closing Sacred Heart Hospital.

Kenneth Hanover, president and CEO of Bryn Mawr Hospital, and vice president of Main Line Health, Inc., warned, "Sacred Heart's closing is just the tip of the iceberg...Figures that seemed credible less than a year ago that prophesied four beds per thousand of population would be needed have now scaled back to less that one bed per thousand being required, and that 75 percent of hospital beds will be unused."

Hanover reported that U.S. Healthcare and Blue Cross's Keystone Health Plan, both health maintenance organizations, control 28 percent of the insurance market. He sees a consolidation into four or five large hospitals and warns that physicians, as they now practice, will not be able to survive.

Joseph R. Carver, MD, a board-certified cardiologist and medical director for U.S. Healthcare, said, "Physicians must be accountable and must have verifiable data on the quality of care they provide." He also said, "There are 500 cardiologists in the Delaware Valley. That is enough to take care of everyone east of the Mississippi." He contends that not all of them will survive; thus, physicians must start getting on panels, lists of sanctioned providers supplied by major insurers.

Rolan Morris, Esq., warned physicians who are forming large groups to control prices in a region: "In building these groups, there will be serious antitrust questions." He said the law typically lags behind practice, and many of the concerns of physicians entering this new business climate have not been addressed.

Dr. Carver added that U.S. Healthcare is looking for physicians whose treatment is appropriate and in line with reasonable and good medicine, and willing to change to work with them. He concluded that change is inevitable, and his organization is looking for ways to work with people and "not take food out of their mouths."

During the reception that followed, a physician in attendance, when asked if he learned anything new, replied, "Yes. I learned what I thought was bleak is now bleaker."

U. Berkley Ellis, EdD, executive director of the Montgomery County Medical Society, contributed to this article.

MAGAZINE TO PUBLISH PITTSBURGH EDITION

A New York City-based health care magazine is expected to release its first Pittsburgh edition this month with funding from the Pittsburgh Business Group on Health, a nonprofit organization representing 28 of the city's largest employers.

Health Pages, which debuted in St. Louis in November 1993, publishes cost comparisons and other data on local physicians, hospitals, and managed care insurers. Past features have included guides to otolaryngologists, urologists, and breast cancer surgeons. Each compared prices, physician education, hospital affiliations, and office hours. Also, there have been primers on managed care terms and articles on preventive medicine.

The Allegheny County Medical Society (ACMS), in the *Pittsburgh Business Times,* offered support for *Health Pages.* "We certainly support anything that provides objective information to the public on health →

care," said John Krah, ACMS executive director.

The publisher estimates that between 30,000 and 80,000 copies will be printed for the publication's Pittsburgh debut. Pittsburgh is the publication's second market; future editions are also planned for Atlanta and Boston.

BERKS CMS SPONSORS LEGISLATIVE BREAKFAST

The Berks County Medical Society in May sponsored its third annual legislative breakfast. Nine state legislators and 86 Berks County physicians attended the event, held at Chef Alan's West Reading Hotel.

Guests included: Senators David J. Brightbill (R-Lebanon) and Michael A. O'Pake (D-Berks); Representatives David G. Argall (R-Schuylkill), Dante Santoni Jr. (D-Berks), Thomas R. Caltagirone (D-Berks), Samuel E. Rohrer (R-Berks), Sheila Miller (R-Berks), Dennis E. Leh (R-Berks), and Paul W. Semmel (R-Lehigh). Also, Tim Smith attended, representing Congressman Timothy Holden.

Each member of the legislative panel spoke for five minutes, followed by physician questions and comments.

SPECIALTIES' NEWS

OTOLARYNGOLOGISTS ELECT NEW OFFICERS

Dr. McKenna

Ernest L. McKenna Jr., MD, Wayne, was installed as president of the Pennsylvania Academy of Otolaryngology-Head and Neck Surgery at the academy's annual convention in June. Dr. McKenna succeeds Frank I. Marlowe, MD, Philadelphia.

A former president of the Philadelphia Laryngological Society and former chairman of the Philadelphia College of Physicians, Section of Otolaryngology, Dr. McKenna is clinical professor, Department of Otolaryngology, Jefferson Medical College of Thomas Jefferson University, Philadelphia. He also serves as president of the medical staff and senior attending otolaryngologist at Bryn Mawr Hospital.

At the same time, Alan W. Miller, MD, Norristown, was voted president elect to succeed Dr. McKenna at the end of his term in June 1995. Carl L. Reams, MD, Danville, was elected secretary-treasurer, the office held for three years by Dr. Miller.

Also at the convention, the academy presented its highest honor, the Distinguished Service Award, to Louis D. Lowry, MD, professor and chairman of otolaryngology, Jefferson Medical College, and George H. Conner, MD, professor and chairman of otolaryngology, Penn State's Milton S. Hershey Medical Center, Hershey. Dr. Lowry served as the first president of the academy when it was formed as an independent society in 1991. Dr. Conner is a past president of the former Pennsylvania Academy of Ophthalmology and Otolaryngology.

YPS NEWS

YOUNG PHYSICIANS PLAN OCTOBER ASSEMBLY

The State Society's Young Physician Section (YPS) will hold its Eighth Annual Assembly meeting on October 20, 1994, at the Hershey Lodge and Convention Center.

An educational program, "Improving Cost-Effective Decision Making," will be held from 1:00-4:00 p.m. Presented by David Shulkin, MD, director of clinical outcome assessment and quality management, University of Pennsylvania, Philadelphia, the program will provide participants with skills to address issues on cost-effective decision making. Category I continuing medical education credit is pending.

Also at the meeting, young physicians may sign up to participate in the YPS computer network, piloted this year to the YPS Governing Council and now available to all young physicians.

The assembly is free to Society members and $60 for nonmembers. For more information, call the YPS at (800) 228-7823 or (717) 558-7750.

AMA-YPS awards

Each year, the AMA Young Physician Section awards community service awards for exemplary projects completed by young physicians. For more information about the 1995 awards program, call the AMA Department of Young Physician Services at (312) 464-4748.

MEDICAL SCHOOL NEWS

PHILADELPHIA PROGRAM BRIDGES GAPS IN CARE

Students from six medical and other health professional schools in Philadelphia participated this summer in "Bridging the Gaps: Philadelphia Community Health Internship Program."

Under the program, first-year medical students work side-by-side with nursing, dental, social work, law, and physical and occupational therapy students to address the health care needs in underserved communities surrounding their institutions. Projects range from homeless shelters to summer day camps to community health clinics.

During its first three years, the program has evolved from 18 students at a single medical school working within the local community, to a multi-institutional, interdisciplinary collaborative effort spanning the city. This year, approximately 150 students participated.

Program officials cite several benefits: Future health care professionals are gaining a comprehensive view of the communities in which they live and learn medicine. This in turn is creating a pool of trainees who understand the importance of preventive medicine, the need for primary care providers, and the importance of community responsive health services. Also, residents of Philadelphia's more underserved areas are benefiting from the help of students who are committed to bringing about change through direct service.

During the next year, the Philadelphia consortium is hoping the work with other academic health institutions in Pennsylvania, possibly to institute similar programs in their areas. The group also hopes to disseminate a service/training model nationally by 1997.

MCP, HAHNEMANN RECEIVE GENERALIST GRANT

The schools of medicine of the Medical College of Pennsylvania (MCP) and Hahnemann University

are among 16 in the nation to receive an implementation grant from the Robert Wood Johnson Foundation's $32.7 million Generalist Physician Initiative. The Commonwealth of Pennsylvania also will contribute $1.5 million over three years for generalist medical education.

The foundation's initiative is designed to develop programs and partnerships that will encourage a higher percentage of medical students to choose careers in family medicine, general internal medicine, and general pediatrics. It responds to a decreasing supply of physicians in these fields, which coincides with an oversupply of physicians in many other specialties.

Beyond being in the select group of grant recipients, the two schools of medicine are the first in the U.S. to merge since World War I. The combined institution will accept its first unified class in 1995.

Hahnmann's Brain Tumor Center

In related news, Hahnemann University Hospital has established The Brain Tumor Center at Hahnemann to provide comprehensive, multidisciplinary services for patients with brain tumors.

Dedicated to treating some of the most difficult brain tumor cases, the center draws on the broad array of Hahnemann professionals and services in neurology, neurosurgery, radiation and medical oncology, radiology, pathology, nuclear medicine, ophthalmology, neuropsychology, social work services, and rehabilitation. This multidisciplinary approach offers brain tumor patients a greater chance of getting the most appropriate treatment plan from among several available options.

NIH GRANT TO EXPAND DISEASE RESEARCH AT PITT

Researchers at the University of Pittsburgh School of Medicine have received a grant in excess of $1 million from the National Institutes of Health (NIH) to expand their investigation of possible environmental and genetic causes of childhood Hodgkin's disease.

The case-control study, currently involving 300 patients with the disease and 484 control subjects from across the U.S. and Canada, will be expanded to study a total of 415 patients and 675 control subjects.

To date, the study has found that approximately 36 percent of the Hodgkin's disease cases have Epstein-Barr virus in their tumor tissues, according to Seymour Grufferman, MD, DrPH, professor and chairman of family medicine and clinical epidemiology at the school, and principal investigator for the study. He says the expanded study will look at the role of the virus through molecular testing, as well as risk factors such as breast feeding, socioeconomic status, parents' use of recreational drugs during pregnancy, childhood environmental exposures, and parents' occupational and environmental exposures.

"Health of the Public"

In related news, the University of Pittsburgh has been selected to participate in the $7.8 million "Health of the Public" program, sponsored by the Pew Charitable Trusts and the Robert Wood Johnson Foundation.

The university is one of 28 academic health centers developing projects that emphasize the "population perspective" in health professions education, patient care, and research. Pitt will use program resources to work with residents of Terrace Village—a Pittsburgh public housing project—to identify health-related problems and implement useful solutions for them.

BECK PSYCHIATRIC INSTITUTE OPENS IN BALA CYNWYD

Aaron T. Beck, MD, one of the world's leading psychiatrists and psychological theorists and universally recognized as the founder of the form of psychotherapy known as cognitive therapy, and Judith S. Beck, PhD, renowned cognitive therapist, author, and international speaker, announced the opening of the Beck Institute for Cognitive Therapy and Research in Bala Cynwyd on July 1.

The new, nonprofit institute is the fulfillment of a dream shared by father and daughter, Aaron and Judith, who envision it as the area's premier treatment center for cognitive therapy, and the international headquarters for training cognitive therapists and

Drs. Judith and Aaron Beck

disseminating information about cognitive therapy throughout the world. The institute will offer complete psychological and psychiatric services including evaluation, cognitive therapy, and pharmacology when indicated.

MEDICAL STUDENT NEWS

PENN STATE HOSTING CAREER DAY CONFERENCE

The Pennsylvania State University Chapter of the American Medical Student Association will hold a Career Day Conference on Saturday, October 15, 1994, at Penn State's Milton S. Hershey Medical Center, Hershey.

Speakers will discuss the business aspect of medicine, getting the residency of your choice, and health care in the next century. Also, alumni of Penn State's College of Medicine will talk about their specialties.

For more information, write to David Chang, Medical Student Box 485, P.O. Box 850, Hershey, PA 17033.

PMSLIC ISSUES SEMI-ANNUAL CLAIMS STATISTICS REPORT

The Pennsylvania Medical Society House of Delegates Resolution 86-17 requires that the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) report certain claims statistics to the House of Delegates on a semi-annual basis.

In response to this resolution, PMSLIC published the first semi-annual report in the September 1987 PENNSYLVANIA MEDICINE. The data included in the following tables is an update of PMSLIC's claims experience as requested by the resolution.

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Note: To more accurately reflect PMSLIC's experience, the tables have been expanded this year to include all claims and suits indexed against PMSLIC insureds since the company's inception in 1978. The following tables represent data for January 1, 1978 through June 30, 1994.

Table 1 (below): Joinders—Includes PMSLIC physicians joined by other parties and other parties joined by PMSLIC.

Table 2 (at right): Number of claims and suits filed by specialty, January 1, 1978-June 30, 1994.

Table 3 (page 33): Breakdown of PMSLIC claims and suits filed by specialty, January 1, 1978-June 30, 1994.

Direct any questions or comments about this material to Jane L. Conley, Director of Medical Research and Statistics, PMSLIC, P.O. Box 8375, Harrisburg, PA 17105-8375, (717) 558-7500, extension 501.

TABLE 1: Number of cases in which a physician is joined as an additional defendant by a hospital or physician

Since beginning tracking joinder data on April 7, 1987, 120 PMSLIC insureds were joined by other parties through June 30, 1994, as follows:

PMSLIC Insured Joined By:	Number of Times:
Hospital	58
Other Physician	26
Nursing Home	3
Commercial Business	8
Plaintiff	4
Pharmacy/Pharmacist	9
Manufacturer	2
Drug Company	3
Other	7
TOTAL	**120**

During the same period, PMSLIC joined 21 other parties, as follows:

Party Joined By PMSLIC:	Number of Times:
Hospital	2
Physician	11
Drug Company	1
Manufacturer	4
Other	3
TOTAL	**21**

TABLE 2: Number of claims and suits filed by specialty from January 1, 1978-June 30, 1994

Specialty	Total Claims and Suits	Specialty	Total Claims and Suits
Allergy	21	Pathology	52
Anesthesiology	465	Pediatrics	423
Cardiac Surgery	31	Plastic Surgery	391
Cardio-Thoracic Surgery	64	Preventive Medicine	1
Cardio-Vascular Surgery	139	Proctology	11
Cardio-Vascular & Thoracic Surgery	141	Psychiatry	75
Cardiology	338	Pulmonary Diseases	3
Colon-Rectal Surgery	1	Radiation Oncology	1
Dermatology	134	Radiology	647
Emergency Medicine	373	Rehabilitation/Physiatry	119
Endocrinology	1	Rheumatology	13
Family Practice	755	Thoracic Surgery	72
Gastroenterology	46	Urology	256
General Practice	756	Vascular Surgery	34
General Surgery	1,641	Vascular/Thoracic Surgery	7
Geriatrics	1	Physicians NOC	96
Gynecology	71	***Other Practitioners***	
Hematology	2	Clinical Psychologist	1
Hematology/Oncology	12	Nurse Anesthetist	19
Industrial Medicine	17	Nurse Midwife	4
Infectious Diseases	7	Nurse Practitioner	2
Internal Medicine	1,800	Physician's Assistant	6
Nephrology	7	Physiotherapist	2
Neurology	157	Registered Nurse	7
Neurosurgery	411	Surgical Technician	4
Nuclear Medicine	3	X-Ray Technician	2
OB/GYN	1,639	Other Practitioner	1
Oncology	17		
Ophthalmology	374	Corporate Liability	1,245
Orthopedics	23	Partnership Liability	59
Orthopedic Surgery	1,758		
Otolaryngology	291	**GRAND TOTAL**	**15,049**

Keep in mind that the specialty totals are affected in part by the number of PMSLIC insureds in each specialty. In addition, some specialties are relatively new rating classifications and were not in existence for the entire time period represented.

Next Month in Pennsylvania Medicine...

Medicine just isn't what it used to be—reform, technology, and mergers have quickly become household words.

Next month, PENNSYLVANIA MEDICINE takes a look at the changes in medicine with a feature on new computer options and a special insert updating memebrs on health system reform, hospital mergers, Pennsylvania Blue Shield changes, and the progress of the Society's newest subsidiary—the PennMed Member Services Company (PSMSCO).

Also, look for a one-on-one with John H. Hobart, MD, president elect of the Society.

October issue due in your mailbox mid-month.

TABLE 3
Breakdown of PMSLIC Claims and Suits Filed by Specialty
January 1, 1978–June 30, 1994*

Physician Specialty	# Open C & S	Closed Settlement No Loss Payment # C & S	Avg Exp Pmt	Clased Verdicts Na Loss Payment # C & S	Avg Exp Pmt	Closed Settlements With Loss Payment # C & S	Avg Loss Pmt	Avg Exp Pmt	Closed Verdicts With Loss Payment # C & S	Avg Loss Pmt	Avg Exp Pmt
Physician Specialties											
Allergy	11	5	$ 2,072	0	$ -0-	5	$30,500	$ 9,874	0	$ -0-	$ -0-
Anesthesiology	80	191	9,550	19	21,714	172	30,721	4,351	3	74,333	11,884
Cardiac Surgery	7	19	12,343	3	25,760	2	26,250	498	0	-0-	-0-
Cardio-Thoracic Surg.	17	33	9,912	3	28,287	11	79,091	20,860	0	-0-	-0-
Cardio-Vasc. Surg.	24	61	11,062	7	38,878	44	71,065	10,463	3	166,667	36,336
Cordio-Vosculor & Thoracic Surgery	51	66	6,071	4	25,389	17	88,412	14,916	3	72,678	41,016
Cardiology	148	160	6,287	1	28,255	28	83,354	12,772	1	1,750	11,857
Colon-Rectal Surgery	0	1	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Dermatology	28	67	9,188	9	24,756	29	33,598	8,054	1	24,000	32,485
Emergency Medicine	57	184	15,812	27	22,931	93	59,995	8,573	12	30,283	12,008
Endocrinology	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Family Practice	253	317	6,898	33	27,053	147	88,509	10,405	5	87,395	21,068
Gastroenterology	9	25	10,112	1	9,577	11	51,659	14,477	0	-0-	-0-
General Practice	127	349	12,134	42	31,466	232	61,609	9,211	6	39,942	16,953
Generol Surgery	251	729	5,396	113	24,612	523	69,319	9,911	25	98,440	27,491
Geriatrics	0	1	8,658	0	-0-	0	-0-	-0-	0	-0-	-0-
Gynecology	9	31	4,652	2	26,150	28	72,732	9,035	1	3,289	2,388
Hematology	1	1	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Hematology/Oncology	10	2	1,318	0	-0-	0	-0-	-0-	0	-0-	-0-
Industriol Medicine	1	11	2,619	1	6,164	3	133,500	23,630	1	4,000	5,241
Infectious Diseases	4	3	6,394	0	-0-	0	-0-	-0-	0	-0-	-0-
Internal Medicine	509	853	6,534	83	26,153	336	70,436	11,638	19	81,676	43,442
Nephrology	3	4	5,884	0	-0-	0	-0-	-0-	0	-0-	-0-
Neurology	40	93	6,216	6	20,220	17	85,676	13,216	1	50,000	755
Neurosurgery	86	199	6,826	25	38,286	93	78,928	17,931	8	118,889	28,671
Nuclear Medicine	0	2	2,247	0	-0-	1	60,000	75	0	-0-	-0-
OB/GYN	352	677	5,759	95	30,840	477	81,688	10,587	38	75,428	28,494
Oncology	8	8	236	0	-0-	1	4,000	1,948	0	-0-	-0-
Ophthalmology	92	186	3,285	23	24,233	71	74,846	8,630	2	119,523	21,562
Orthopedics	0	14	4,918	2	20,066	7	27,429	7,373	0	-0-	-0-
Orthopedic Surgery	216	868	5,003	146	27,844	505	62,933	9,761	23	83,815	29,301
Otolaryngology	37	145	4,870	27	22,659	74	57,071	9,537	8	67,115	34,453
Pothology	19	19	6,835	2	52,840	11	84,682	11,423	1	8,333	3,038
Pediatrics	138	174	6,646	27	33,046	79	96,793	14,906	5	134,710	40,221
Plastic Surgery	122	155	4,121	24	23,902	83	41,046	7,551	7	64,367	34,916
Preventive Medicine	0	1	21,584	0	-0-	0	-0-	-0-	0	-0-	-0-
Proctology	0	3	8,636	0	-0-	8	130,000	14,802	0	-0-	-0-
Psychiatry	21	36	6,971	6	30,838	12	60,858	15,191	0	-0-	-0-
Pulmonory Diseases	2	1	1,571	0	-0-	0	-0-	-0-	0	-0-	-0-
Radiotion Oncology	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Rodiology	161	347	5,292	13	36,812	118	59,573	9,665	8	57,080	20,643
Rehabilitation/Physiatry	53	57	7,103	4	19,065	5	109,500	13,869	0	-0-	-0-
Rheumatology	9	3	6,966	1	42,566	0	-0-	-0-	0	-0-	-0-
Thoracic Surgery	8	42	8,183	0	-0-	21	70,835	8,373	1	83,718	42,612
Urology	57	106	5,168	19	22,214	68	49,175	8,494	6	108,581	34,789
Vascular Surgery	10	15	5,626	2	34,096	7	79,643	18,351	0	-0-	-0-
Vasc. & Thorocic Surg.	2	5	3,719	0	-0-	0	-0-	-0-	0	-0-	-0-
Physicians NOC	17	46	5,661	8	26,831	23	33,188	4,951	2	181,392	70,304
Other Practitioners											
Clinical Psychologist	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Nurse Anesthetist	2	6	3,852	0	-0-	11	22,028	2,183	0	-0-	-0-
Nurse Midwife	1	1	18,793	0	-0-	2	62,728	4,516	0	-0-	-0-
Nurse Practitioner	1	0	-0-	1	6,265	0	-0-	-0-	0	-0-	-0-
Physician's Assistant	3	1	1,425	0	-0-	2	80,000	91	0	-0-	-0-
Physiotherapist	1	0	-0-	0	-0-	1	5,000	-0-	0	-0-	-0-
Registered Nurse	0	5	4,693	0	-0-	2	5,500	134	0	-0-	-0-
Surgical Technician	3	1	6,813	0	-0-	0	-0-	-0-	0	-0-	-0-
X-Ray Technician	1	1	1,484	0	-0-	0	-0-	-0-	0	-0-	-0-
Other Practitioner	0	0	-0-	0	-0-	1	4,000	2,923	0	-0-	-0-
Corporate Liability	668	462	4,961	52	19,172	55	84,590	11,514	8	123,356	-0-
Partnership Liability	33	20	5,434	4	20,486	2	53,500	2,704	0	-0-	-0-
GRAND TOTALS	**3,766**	**6,812**	**$5,374**	**835**	**$26,922**	**3,438**	**$67,549**	**$10,101**	**198**	**$82,181**	**$28,677**

** Claims and suits filed during this period resulted from policy years 1978-1994. PMSLIC's limit of liobility is $100,000 per incident for policy years 1978-1982, $150,000 for 1983, and $200,000 for 1984-1994.*

Keep in mind that the specialty totals are affected in part by the number of PMSLIC insureds in each specialty. In addition, some specialties are relotively new rating classifications and were not in existence for the entire time period represented.

Pediatricians Target Child Care Programs

Maureen Hoepfer

Susan S. Aronson, MD, FAAP, is a clinical professor of pediatrics at the University of Pennsylvania and a primary care pediatrician at the Children's Hospital of Philadelphia. Since the early 1970s, Dr. Aronson has been involved in efforts to improve early childhood care and education programs in Pennsylvania. Currently, she serves as director of the Early Childhood Education Linkage System of the Pennsylvania Chapter of the American Academy of Pediatrics. The program provides health professional consultation, training, and technical assistance to improve early childhood education and child care programs in the commonwealth.

More than one-third of children under the age of five are in some kind of group care setting, according to the U.S. Census Bureau. Unlike their school-age counterparts, these younger children in group care often have no immediate access to health professional input. "Most child care programs do not have a nurse who visits the site or who they can call if they have questions, which is available today in all Pennsylvania schools," says Susan Aronson, MD. "And these child care programs serve younger, more vulnerable children than are found in most schools."

Dr. Aronson says improving the quality of care received in early childhood settings has been a high professional priority for her. "Child care is a part of our social network that has received too little attention and support," she explains. "Each of us has a responsibility to nurture children because each child is a potential precious replacement for ourselves. We must take care of every one of them."

Dr. Aronson

Early involvement was spark

Dr. Aronson's first exposure to child care programs was as a consultant for Head Start, an early childhood education program sponsored by the federal government. "I learned about the early childhood education profession and the uniqueness of group care from that experience," she says. "Many of my colleagues asked me why I was dedicating so much attention to this area, which was not considered a legitimate professional focus in medicine at that time. I felt that although I could interface with families one at a time and help children grow and develop individually through my practice, the opportunity to impact on many children's lives was greater working with child care professionals and their programs."

At that time, Dr. Aronson was on the faculty at the Medical College of Pennsylvania. She teamed up with Richard Fiene, PhD, a policy research planner with the Pennsylvania Department of Public Welfare (DPW), to develop a health advocacy training program which sought to link health professionals with early childhood education professionals working in group care settings.

The program was federally funded as a demonstration project, but fell victim to federal cutbacks a few years later and ceased to exist in 1980. "Between 1980 and 1989, the people we had trained in Pennsylvania had no support system to back them. We needed to rebuild and expand the support."

In 1988, Dr. Aronson drew together a working group that included representatives from both the state and federal governments, and health care and child care profession-

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

als. "We looked at what we could do and how we could do it in Pennsylvania," she says. "We decided we needed to gather the various health, education, and safety resources useful to child care providers across the state and then link these resources with the child care providers."

"ECELS" provides vital link

Start-up funding for the Early Childhood Education Linkage System (ECELS) came from federal Title V Maternal and Child Health Improvement Program and Robert Wood Johnson Foundation grants. Because of the level of funding received, the program was implemented statewide from the beginning. The Pennsylvania Chapter of the American Academy of Pediatrics, for which Dr. Aronson served as president from 1984-1988, administers the program.

To improve the quality of group care, ECELS has focused on the following areas:

- *Consultation:* ECELS provides telephone advice to 200-300 callers a month. After advising the caller, a program staff member offers a linkage with a local health professional for further support. Currently, the ECELS resource list includes 800 health consultants. Although the bulk of these consultants are nurses, approximately 180 are physicians. The ECELS registry also includes dentists, optometrists, physical and occupational therapists, speech pathologists, and various other health professionals.
- *Training:* To address the ongoing need for entry-level training of child care professionals, ECELS arranged the delivery of more than 6,000 units of the American Red Cross Child Care Course to child care providers statewide. ECELS has also recruited and trained more than 130 instructors who teach child care workers and others how to check child immunization records. Additional training offered or arranged by ECELS covers preventing pedestrian, bicycle, and motor vehicle injury; infant and toddler health issues; and the role of the health consultant.
- *Educational Materials:* ECELS publishes a quarterly newsletter, *Health Link*, which is distributed to all licensed or registered early childhood programs in the state, and operates a free lending library of audiovisual materials. The program staff has also developed a training curriculum for child care providers, a model booklet of health care policies, fact sheets on common childhood diseases and health problems, and various administrative forms, such as health assessments, playground supervision schedules, and communication between parents and staff.
- *Surveillance and Targeted Assistance:* ECELS uses pooled performance data collected from early childhood programs since 1990 to identify common problems. The data are used to select topics covered in the newsletter, training offerings, and targets for resource development. During 1992, ECELS taught all Pennsylvania child care licensing inspectors how to check children's records for complete immunizations and other routine health services. Now, the licensing staff routinely sample 10 percent of records at each site. The state then aggregates the data, and forwards the summary and raw data to ECELS for corrective action. ECELS contacts child care providers whose health care records show children lacking immunizations or other routine health services. ECELS staff members arrange for local health professionals to work with the child care programs on improving documentation and linking children who need services with a medical home.

Child care study reveals needs

Dr. Aronson says an evaluation component was built into the ECELS proposals when the work group first applied for grants. Dr. Fiene drew a study population of child care professionals from a state list of child care facilities that included Head Start programs, nursery schools, family child care homes, and child care centers.

"During the demonstration period between 1990 and 1993, we measured the performance of the providers, and the results showed that even with very limited hours of contact with health professionals, the programs significantly improved. Those programs that had assigned nurse consultants made even greater gains than those that did not."

As a result of these evaluations, the Pennsylvania Chapter of the American Academy of Pediatrics was able to justify maintaining the ECELS program after the original grants ran out. The program is currently funded through contracts with both the Pennsylvania Departments of Health and Public Welfare.

Dr. Aronson says that ECELS has made steady progress in upgrading its services and demonstrating that the program is helping child care providers improve the quality of their care. "We still have a lot of work to do," she emphasizes. "Our goal is to ensure there is quality child care available to every child in Pennsylvania. We're a long way from achieving that success."

Want to Help?

Physicians have many opportunities to improve the child care environment in their communities, according to Susan S. Aronson, MD. Child care centers, Head Start programs, and other early childhood education facilities are always looking for physicians to serve on their boards or become medical advisers. ECELS also encourages physicians to volunteer for its health consultant registry.

The registry offers physicians various options for becoming involved. For example, a physician may choose to work with a specific child care and early childhood education program, teach classes on health-related topics to child care providers, be available for telephone consultation to a child care provider, or provide routine health care services for children in group settings who lack needed care. Although the time commitment varies depending on what area a physician chooses, on average an ECELS health consultant donates six or seven hours a year to the program.

For more information about the ECELS program, or to enroll as a health consultant, call JoAnn Martin, MA, MSN, RN, ECELS coordinator, at (800) 24-ECELS.

New Doctors Entering Revived Market

The Health Care Grap

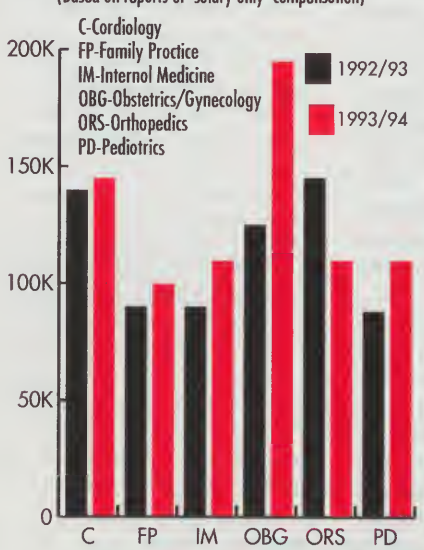
For the past several years, as health system reform loomed on the horizon, physicians' starting salaries seemed to reflect the expected change to a tighter market, with little or no increases and decreased fringe benefits.

Perhaps it is no coincidence, then, that since President Clinton's health system reform plan has become stalled over the past year, starting salaries for new physicians have increased, in some cases rather dramatically, from the previous year. In 1991 and 1992, salaries for specialties were flat or actually decreased, while primary care physicians (family practice, pediatrics, and general internal medicine) showed slight increases as buyers for these practices competed to offer the best purchase price.

Fringe benefits still down

However, higher salaries were not matched this year with more or better fringe benefits. For the second consecutive year, hiring physicians and groups are being more restrictive. Even traditional benefits, such as vacation and continuing medical education time, are not being offered by a larger number of employers.

Average Starting Salaries of Selected Specialties
(Based on reports of "salary only" compensation)



There is encouraging news concerning salaries for physicians—specialists and primary care givers alike—hunting for their first jobs. When looking at salary alone, obstetrician-gynecologists had the most dramatic jump in salaries, but other specialties, such as cardiology, also increased (see graph, below left). Orthopedists were one of the few specialties that suffered a decrease in starting salary. However, when comparing salary and incentives, orthopedists' compensation increased dramatically.

Salary, compensation reflect competition

Salary and compensation, as compared to salary alone, continue to make up the majority of compensation arrangements in new physicians' contracts, reflecting the competitive nature of today's health care environment. For the second consecutive year, 59 percent of new physicians' contracts have included salary and incentive arrangements. This trend has been increasing steadily: Two years ago it was 57 percent and three years ago 52 percent.

The biggest salary increases occurred in the more rural regions of the country, showing that physicians in those locations need to pay more to attract doctors. Increases also were seen in the regions preferred most by young doctors.

Trends from the past year

Several other trends have developed over the past year:

- Only 61 percent of this year's contracts show a provision for *restrictive covenants* or liquidated damages. This seems to reflect a lack of concern from hospitals and other entities about young physicians leaving the practice to compete. Last year, 72 percent of the contracts included restrictive covenants.
- As for *malpractice coverage*, there was a distinct shift toward occurrence coverage away from claims made coverage. This may reflect a general trend toward this type of arrangement for all physicians, as well as an indication of the economic situation.
- As salaries increase, *fringe benefits* provided have been tightened. For instance, sharp drops were recorded in the number of employers who provide subscriptions to medical journals, payment and time allowances for continuing medical education, and sick time. Even the number of employers who provide vacation for the first year of employment decreased, from 96 percent last year to 93 percent this year.
- The only increases came in *pension/profit sharing*, from 58 percent last year to 64 percent this year, and *automobile reimbursements*, from 24 percent to 26 percent, respectively. Three-quarters of employers who offer pensions begin eligibility within the first year, with 23 percent offering it after two years, and three percent after three years.
- An interesting change from 1993 was the number of *sick days* provided. As in 1993, 41 percent offered 10 to 20 days of sick leave in the first year of employment, but no employers offered 21 to 30 days of sick leave, a plunge from 34 percent last year. Instead, 26 percent offered 31 to 50 days, and 30 percent offered fewer than 10, an increase from last year when 21 percent offered fewer than 10 sick days in the first year.
- The number of employers providing health insurance, disability insurance, and medical society dues decreased, but not by significant amounts.

Although the increase in physicians' starting salaries was good news after two years of little change, it will be interesting to note the effect on salaries if some form of health care legislation is passed later this year.

The contributing author, Dorothy R. Sweeney, is a consultant with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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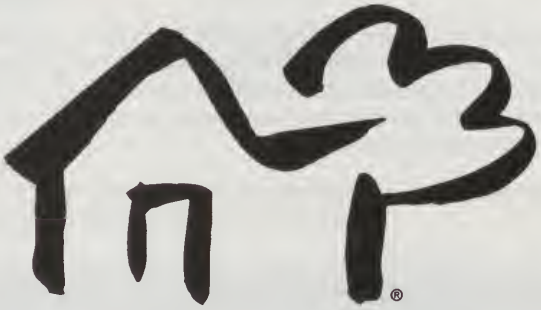

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ACTIONS OF THE BOARD OF TRUSTEES, JULY 15-17, 1994

STRATEGIES FOR CHANGE REVIEWED BY BOARD

Following more than a year of study, the Society's Task Force to Enhance Physician Involvement presented to the Board of Trustees, at a special July retreat, 14 recommendations for organizational change.

The task force, headed by Robert N. Moyers, MD, past Society president, brought together physicians of various ages, backgrounds, and interests to investigate and initiate means to enhance the Society's strengths. Through studies, surveys, focus groups, staff response, and intense discussions, the task force identified strategic initiatives.

The board approved in concept recommendations that would:

- allocate the Society's resources based on membership priorities;
- provide an internal evaluation process to continually examine the effectiveness of Society programs and activities; and
- expand two-way communication between members and leadership through use of new technologies.

The board also approved the concept of a recommendation from the board to the 1994 House, outlining ways in which the House could more closely focus its business on priority issues.

Prioritization

A major focus of task force recommendations was establishing and maintaining membership priorities within the budget.

The task force stated, "Now, in a time of finite resources, to better serve its membership the Society must prioritize initiatives based on a systematic and continual process of collection, analysis, and response to grassroots needs and desires."

The task force also suggested that the board revise its reporting requirements to ensure that all recommendations submitted by other bodies are consistent with established priorities.

Membership-driven process

A second means for prioritization recommended by the task force was the development of a "membership-driven process." This term was coined by the task force to describe an organization that responds to the needs of its entire membership, rather than to an individual member's needs and wants.

The process would include five steps: 1) obtain input from members, and gather external data; 2) analyze input and data; 3) establish priorities based on input and data; 4) act on established priorities; and 5) provide feedback, including priorities and associated benefits, to membership.

Communication/infrastructure

The board approved the concepts recommended by the task force to expand two-way communication with the membership.

However, rather than "top-down communication" from leaders to members, the task force emphasized that the Society should investigate use of emerging technologies, better allocation of communication resources, and other means to remain flexible and responsive to the needs of the membership-driven process.

Noting that transforming the Society into a "membership-driven" organization will require participation by all the major Society organizational entities, the task force suggested that a study of the Society's infrastructure be initiated.

Details on implementating the task force's recommendations are to be considered at the board's September meeting.

Unification reports prepared

The board also heard a report on a resolution of the 1993 House of Delegates which called for a study of the effects of unification with the AMA. The report, with additional information requested by the board, will be submitted to the 1994 House. The board may also make its own recommendation to the House on the matter.

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SEPTEMBER 1994

September 21st
Renal Tubular Acidosis
Neil A. Kurtzman, M.D.
Arnett Professor of Medicine
Chairman of Internal Medicine
Texas Tech Health Sciences Center
Lubbock, TX

September 28th
Polycythemia Vera: Understanding of Clinical, Viral and Genetic Mechanisms
Isadore Brodsky, M.D.
Professor and Associate Chair
Department of Medicine
Director of Hematology/Oncology
Hahnemann University

OCTOBER 1994

October 5th
Pulmonary Tuberculosis: Changing Pattern of Epidemiology and Therapy
Michael E. Iseman, M.D.
Associate Professor of Medicine
Mycobacterial Disease Service
Infectious Diseases Division
National Jewish Center
Denver, CO

October 12th
Coronary Heart Disease in Women
Nanette K. Wenger, M.D.
Professor of Medicine
Emory University School of Medicine
Director, Grady Health Systems
Atlanta, GA

October 19th
New Approaches to Infections in Organ Transplant Recipients
Robert H. Rubin, M.D.
Professor of Medicine
Harvard Medical School
Infectious Disease Division
Massachusetts General Hospital
Boston, MA

October 26th
Treatment of the Geriatric Patient
Joel Posner, M.D.
Professor of Medicine
Director, Division of Geriatrics
Medical College of Pennsylvania
Philadelphia, PA

NOVEMBER 1994

November 2nd
Clinical Diagnosis of Heart Disease for the Generalist
David H. Spodick, M.D., D.Sc.
Professor of Medicine
Cardiology Division
Saint Vincent Hospital
Worcester, MA

November 9th
Thyroid Disorders and the Heart
Paul Ladenson, M.D.
Professor of Medicine
Director, Division of Endocrinology and Metabolism
Johns Hopkins School of Medicine
Baltimore, MD

November 16th
Asthma: Management Strategies
William Busse, M.D.
Professor of Medicine
University of Wisconsin
School of Medicine
Madison, WI

November 23rd
No Grand Rounds—Holiday

November 30th
Kidney Stone Disease
Douglas M. Landwehr, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Nephrology and Hypertension
Allegheny General Hospital
Pittsburgh, PA

DECEMBER 1994

December 7th
Steroid-Induced Osteoporosis
Paul Katz, MD
Professor of Medicine, Microbiology, and Immunology
Chief, Division of Rheumatology, Immunology, and Allergy
Georgetown University School of Medicine
Washington, DC

December 14th
Cardiac Auscultation
Leonard S. Dreifus, MD
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Daniel Mason, MD
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Gerald Scharf, DO
Professor of Clinical Medicine
Division of Cardiovascular Diseases
Hahnemann University

John J. Ross, RCPT
Research Assistant Professor
Division of Cardiovascular Diseases
Hahnemann University

December 21st
Metabolic Bone Disease - Osteodystrophies and Osteoporosis
Harmut Malluche, MD
Professor of Internal Medicine
Chief, Division of Nephrology, Bone and Mineral Metabolism
University of Kentucky
Lexington, KY

December 28th
No Grand Rounds
Holiday

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

September 21, 1994
Edema, Acid-Base, Electrolyte Disorders, Mechanisms & Treatment of Hypertension
Guest Lecturer:
Neil A. Kurtzman, MD

OCTOBER 5, 1994
Tuberculosis
Guest Lecturer:
Michael E. Iseman, MD

NOVEMBER 16, 1994
Asthma
Guest Lecturer:
William Busse, MD

DECEMBER 14, 1994
Cardiac Diagnostic Techniques for the Generalist Physician

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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OBITUARIES

Alexander Blumberg II, MD, *Williamsport*
Emroy University School of Medicine, Georgia, 1932; age 86, died June 11, 1994. Dr. Blumberg was a pediatrician.•

Franklin S. Buzby, MD, *Philadelphia*
Hahnemann University School of Medicine, 1937; age 83, died June 28, 1994. Dr. Buzby specialized in occupational medicine.•

Anthony E. DeTullio, MD, *Philadelphia*
Hahnemann University School of Medicine, 1934; age 86, died June 27, 1994. Dr. DeTullio specialized in public health.•

Ismail Dimililer, MD, *Sunbury*
Istanbul Medical School, Turkey, 1947; age 72, died June 13, 1994. Dr. Dimililer was a general surgeon.•

Gerold J. Effinger, MD, *Langhorne*
Temple University School of Medicine, 1949; age 70, died May 18, 1994. Dr. Effinger was an internist.•

Peter E. Farrell, MD, *Allentown*
Temple University School of Medicine, 1964; age 55, died July 6, 1994. Dr. Farrell was an otolaryngologist.•

Thomas Forker, MD, *Hershey*
Jefferson Medical College of Thomas Jefferson University, 1950; age 69, died May 25, 1994. Dr. Forker was an orthopedic surgeon.•

August Frank Frattali, MD, *Lake Ariel*
Hahnemann University School of Medicine, 1953; age 68, died June 3, 1994. Dr. Frattali was a family practitioner.•

Baldwin L. Keyes, MD, *Wynnewood*
Jefferson Medical College of Thomas Jefferson University, 1917; age 100, died June 6, 1994. Dr. Keyes was a neurologist.•

Harry L. Krieger, MD, *Easton*
Hahnemann University School of Medicine, 1943; age 76, died May 26, 1994. Dr. Krieger was a general practitioner.•

Ping-Tchang Liang, MD, *Allison Park*
Age 76, died June 3, 1994. Dr. Liang was a pathologist.•

Roger E. Mesmer, MD, *Russell*
McGill University Faculty of Medicine, Montreal, Quebec, Canada, 1956; age 62, died May 24, 1994. Dr. Mesmer was a psychiatrist.•

Thaddeus L. Montgomery, MD, *Newton Square*
Jefferson Medical College of Thomas Jefferson University, 1920; age 98, died June 15, 1994. Dr. Montgomery was an obstetrician/gynecologist.•

Sidney G. Radbill, MD, *Bala Cynwyd*
University of Pennsylvania School of Medicine, 1936; age 85, died June 27, 1994. Dr. Radbill was an ophthalmologist.•

Thomas A. Shatten, MD, *Pittsburgh*
Ohio State University College of Medicine, 1977; age 41, died June 28, 1994. Dr. Shatten was a pediatrician.•

Robert G. Stevens, MD, *State College*
Jefferson Medical College of Thomas Jefferson University, 1946; age 72, died June 28, 1994. Dr. Stevens specialized in physical medicine.•

Paul V. Strumia, MD, *Gladwyne*
University of Pennsylvania School of Medicine, 1952; age 66, died July 4, 1994. Dr. Strumia was a pathologist.•

Henry J. Tumen, MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1925; age 92, died June 10, 1994. Dr. Tumen was a gastroenterologist.•

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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Two new members were elected to serve on the board of the Pennsylvania Medical Society Liability Insurance Company (PSMLIC): **Carol E. Rose, MD,** assistant professor, University of Pittsburgh School of Medicine; and **Mark S. Reuben, MD,** staff physician, Department of Pediatrics, St. Joseph's Hospital, Reading.

Governor Robert P. Casey has appointed **Judy Carhart, MD,** Harrisburg, to the state's Board of Podiatry.

Sue Pan

Sue Pan, Pennsylvania Medical Society Alliance immediate past president, Berks County, was appointed to the AMA Alliance Health Promotion Committee. Also, **Barbara Prendergast,** former PMSA president, York County, was re-elected to a third one-year term as field director of the AMA Alliance.

Donna R. Farrell, DO, interim director, clinical education, Philadelphia College of Osteopathic Medicine, has received the American Medical Women's Association 1994 Gender Equity Award for promoting a gender-fair environment for the education and training of women to study and practice medicine.

Dennis Michalak, MD, was named chief, Division of Cardiovascular and Thoracic Surgery, Hamot Medical Center, Erie.

Evan J. Thomas, MD, associate attending psychiatrist, The Institute of Pennsylvania Hospital, Philadelphia, received the Resident of the Year Award from the Philadelphia Psychiatric Society.

Eugene S. Flamm, MD, professor and chairman of neurosurgery, University of Pennsylvania Medical Center, Philadelphia, has been elected to a six-year term with the American Board of Neurological Surgery.

Edward S. Cooper, MD, professor of medicine, University of Pennsylvania Medical Center, Philadelphia, has received the title of "Master" from the American College of Physicians.

Doris G. Bartuska, MD, professor of medicine and director, Division of Endocrinology, Diabetes and Metabolism, Medical College of Pennsylvania, Philadelphia, became a Fellow of the American College of Endocrinology.

St. Francis Medical Center, Pittsburgh, has appointed **Alan H. Klein, MD,** educational director of primary care orthopedics, and **Sang B. Park, MD,** chair, thoracic and cardiovascular surgery.

The Medical College of Pennsylvania, Philadelphia, has named **Jay L. Federman, MD,** as professor of surgery and chief, Division of Ophthalmology.

Canonsburg General Hospital has named **Eugene J. Hammell, MD,** a general surgeon, to its board of directors.

Monongahela Valley Hospital, has named the following officers: **John R. Paluso, MD,** president; **Richard A.**

Specialty Society Elections

Editors Note: At press time, the following election results were available.

John R. Quinn, MD, medical director, Department of Anesthesiology, Lee Hospital, Johnstown, was installed as president of the Pennsylvania Society of Anesthesiologists.

Dr. Vergare

Michael J. Vergare, MD, acting chairman, Department of Psychiatry, Albert Einstein Medical Center, Philadelphia, was installed as president of the Psychiatric Physicians of Pennsylvania. Other officers are: **Thomas L. Horn, MD,** president elect; **William R. Dubin, MD,** vice president; **Gene L. Cary, MD,** secretary; and **Gordon H. Clark Jr., MD,** treasurer.

Eugene N. Myers, MD, professor and chairman, Department of Otolaryngology, University of Pittsburgh, was elected president elect of the American Board of Otolaryngology.

William R. Poller, MD, clinical associate professor of radiology, University of Pittsburgh School of Medicine, was elected as the 1994-95 president of the Pennsylvania Radiological Society.

Russell Bieniek, MD, medical director, Saint Vincent Health Center, Erie, became the 24th president of Pennsylvania Chapter of the American College of Emergency Physicians (PaACEP). Other officers include: **Steven J. Parrillo, DO,** president elect; **Alan T. Forstater, MD,** vice president; **Allan B. Wolfson, MD,** secretary; **Howard G. Hughes, MD,** treasurer; and **Richard M. McDowell, MD,** immediate past president.

Also, **David K. Wagner, MD,** professor and chairman, Department of Emergency Medicine, Medical College of Pennsylvania, Philadelphia, has received PaACEP's Meritorious Achievement Award. Dr. Wagner was given the award for his efforts to guide medical students and physicians to a career in emergency medicine.

The Pennsylvania Academy of Family Physicians has announced election of the following officers: **Neil Lesitsky, MD,** Albrightsville, president; **Lila Stein Kroser, MD,** Philadelphia, president elect; **Peter Cognetti, MD,** Clarks Summit, vice president; **Mark D. Burd, MD,** Danville, vice speaker of the academy's House of Delegates; **John Woodyear Jr., MD,** West Newton, speaker of the house; **Robert M. Kemp, MD,** Lancaster, treasurer; and **Thomas J. Weida, MD,** immediate past president. The academy has also awarded **Irwin Becker, MD,** Philadelphia, "Family Physician of the Year for 1994."

Long, MD, president elect; **James A. Solan, MD,** secretary/treasurer; and **Robert R. Urban, MD,** immediate past president.

Dr. Lannutti

Pat A. Lannutti, DO, Philadelphia College of Osteopathic Medicine professor, co-vice chairman, Department of Internal Medicine, and chairman, Division of General Internal Medicine, has received the 1994 Christian R. and Mary F. Lindback Foundation Award.

Thomas Jefferson University, Philadelphia, has announced the following appointments: **Gregory C. Kane, MD,** assistant professor of medicine; **Leo Katz, MD,** clinical instructor in medicine; **Mary E. Melton, MD,** assistant professor of medicine; **Jeffrey H. Millstein, MD,** clinical instructor in medicine; and **James S. Studdiford III, MD,** assistant professor, Department of Family Medicine.

Chestnut Hill Hospital, Philadelphia, has named **Gerald Bertiger, MD,** director of the hospital's endoscopy unit.

Richard Sullivan, MD, medical director, Chestnut Hill Rehabilitation Hospital, Wyndmoor, is the author of the chapter titled "Rehabilitation of the Amputee" in the textbook *Vascular Surgery: Principles and Practices*.

Frank W. Bowen Jr., MD, director of newborn pediatrics, Pennsylvania Hospital, Philadelphia, has been appointed chapter chair of the Southwest Pennsylvania Chapter of the March of Dimes.

Philadelphia Heart Institute, Presbyterian Medical Center, has named **David M. Elbaum, DO,** co-director of the Heart Repair Program.

B. Franklin Diamond, MD, was appointed chief, Division of Neurology, Abington Memorial Hospital.

Joseph V. Koehler, DO, Norristown, was re-elected to the position of corporate member of Pennsylvania Blue Shield's board of directors.

Freddie H. Fu, MD, Pittsburgh, was elected to the board of directors of the Arthroscopy Association of North America.

Victor M. Bove, MD, chief of clinical services, Wernersville State Hospital, was named a fellow of the American College of Physician Executives.

Toni S.M. Casale, DO, Camp Hill, was appointed as an additional delegate to the Pennsylvania Health Care Cost Containment Council's Education Committee.

Gregory R. Frailey, DO, was appointed medical director, Ambulatory Care Services, Williamsport Hospital and Medical Center.

Hanover General Hospital has announced the following appointments: **Gary J. Baggett, DO,** medical director, Occupations Health Service; and **Steven J. Karp, DO,** medical director, Psychiatric Center.

Dr. Gottlieb

Friends Hospital, Philadelphia, has appointed **Gary L. Gottlieb, MD,** director and chief executive officer for the Northeast Philadelphia Psychiatric Hospital.

The National Alliance for the Mentally Ill has awarded the Exemplary Psychiatrist Award to **Michael Tronetti, DO,** Erie.

Herbert G. Wendelken, DO, was appointed chairman of gynecologic surgery, Springfield Hospital.

Penn State's Milton S. Hershey Medical Center has named **Thomas M. Krummel, MD,** the John W. Oswald professor, chair of the Department of Surgery, surgeon-in-chief of the University Hospital, and director of the Section of Surgical Sciences.

Sharon Kiely, MD, director, Medical Ambulatory Care, The Western Pennsylvania Hospital, Pittsburgh, was one of three physicians appointed by President Clinton as a 1994-95 White House Fellow—special assistant to senior White House officials and cabinet-level officers. The White House Fellows program places exceptionally talented men and women in full-time paid positions for a year at the White House and cabinet-level agencies.

Michael McCarthy, MD, assistant director, Strecker Program for Substance Abuse, and attending psychiatrist, The Institute of Pennsylvania Hospital, was elected as a McLaughlin Candidate Fellow of the American College of Psychoanalysts.

The Pennsylvania Hospital, Philadelphia, has appointed **R. Michael Buckley, MD,** and **Allan B. Wells, MD,** to the hospital's board of managers.

Scot A. Fisher, DO, Villanova, was appointed chairman, Department of Radiation Oncology, by The Graduate Hospital, Philadelphia.

The Pittsburgh Cancer Institute, University of Pittsburgh Medical Center, has appointed **James R. Jett, MD,** co-director, Comprehensive Lung Cancer Center.

Magee Rehabilitation, Philadelphia, has appointed **Daniel E. Weinstein, MD,** medical director, Brain Injury Rehabilitation.

J. David Ogilby, MD, has been named director, Cardiac Catheterization Laboratories, Philadelphia Heart Institute, Presbyterian Medical Center, Philadelphia.

CORRECTION

In *Newsmakers* of the June 1994 issue of PENNSYLVANIA MEDICINE (page 42), Kim Cantees, MD, of Pittsburgh, was inadvertently omitted from the list of State Society physicians named to the AMA's Federation Study Consortium. Dr. Cantees is representing the University Anesthesiology and Critical Care Medicine Foundation on the study group. Her participation also should have been noted in *Policy Briefs, AMA News*, in the July issue of PENNSYLVANIA MEDICINE (page 35).

Workers' Comp: A New Direction

Donald E. Harrop, MD

New amendments to Pennsylvania's workers' compensation law have allowed the Keystone Peer Review Organization to conduct a new type of review and may open other doors, too.

Unlike the provisions of the Automobile Insurance Law (Act 6 of 1990), workers' compensation cases are randomly assigned by the Bureau of Workers' Compensation to utilization review organizations (UROs) for review, after determining the type of review needed in relation to the qualifications of the URO. Also unlike Act 6, new amendments to the Workers' Compensation Act, effective last August, have provided the Keystone Peer Review Organization (KePRO) with the opportunity to become involved with workers' compensation review.

Under Act 6, the insurance companies select their own UROs. Even though KePRO is probably the largest review organization in the state, none of the automobile insurers have selected us for any case review since Act 6 became law about four years ago. Perhaps the auto insurers distrust us because KePRO is a physicians' organization, and they may believe that physicians will be biased in favor of the providers of care.

To start the workers' compensation review on the effective date of the law, the bureau adopted the Insurance Department's list of UROs qualified to conduct Act 6 review. At the time of this writing, the bureau is developing its own criteria for determining the qualifications of a URO. For workers' compensation, KePRO has been classified as a "comprehensive" URO, meaning we are qualified to review cases involving any specialty, including chiropractic, dental, psychological, physical therapy, etc.

Because review of some of these specialties is not included in our Medicare contract, we had to add a whole new cadre of professionals for workers' compensation review. Also, KePRO had to assure that our physician advisers who review for Medicare were agreeable to doing workers' compensation review. The physician advisers were asked to sign an agreement stating that they were willing to perform other review in addition to Medicare review.

With the help of some state associations, other necessary specialists were identified and contacted. Those who agreed to review for us were then put through a credentialing process similar to what we do for Medicare physician advisers.

We received our first case for review on October 18, 1993, and as of June 30, 1994, KePRO had completed review of 102 cases. We are also doing reconsiderations.

Considering that KePRO has probably reviewed close to one-and-a-half-million Medicare cases of various types since starting in business in 1985, we were sure that we knew pretty much all there was to know about review. Admittedly, this caused us to be somewhat indignant when we received a letter of complaint from one of the workers' compensation carriers because we did not provide sufficient detail to explain why a case had been approved. After conversations with the bureau and with the carrier, we realized that there was quite a difference between the expectations of the Health Care Financing Administration (HCFA) and the insurers.

HCFA's main interest in documentation of review results is that an adequate reason be provided in the case of a denial of benefits. They don't seem to worry too much about lack of detail when a physician adviser approves a claim. However, the insurance companies are more concerned with documentation of approvals to assure that they are only paying necessary claims.

This was the only question raised about our workers' compensation review thus far, and our conversation with the carrier apparently resolved the problem. I'm glad we learned our lesson and corrected our problem as quickly as we did.

Hopefully, some of those insurers who underwrite both workers' compensation and automobile insurance will come to realize that KePRO review is fair and unbiased, and may allow us to do some Act 6 review for them as well. Eventually, they may even realize that we are fair and unbiased because of the fact that we *are* a physicians' organization, not in spite of it.

Dr. Harrop is president of the Keystone Peer Review Organization.

Subscribers Receive 15 Percent Dividend

Many State Society members recently received dividend checks representing a 15 percent return of the premium paid for workers' compensation coverage through the Society-endorsed Dodson Workers' Compensation Plan.

This is the twenty-first year in a row that Dodson has returned a dividend to subscribing members. Total dividends paid, which now exceed $3 million, are possible because insured practices keep claims to a minimum.

The dividend payments are in addition to receiving a discounted premium when policies are issued. Dodson workers' compensation insurance continues to be one of the most competitively priced products in the market. Approximately one-third of State Society members now purchase their coverage through Dodson.

For more information, call (800) 825-9489.

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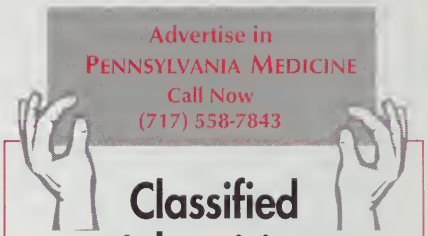

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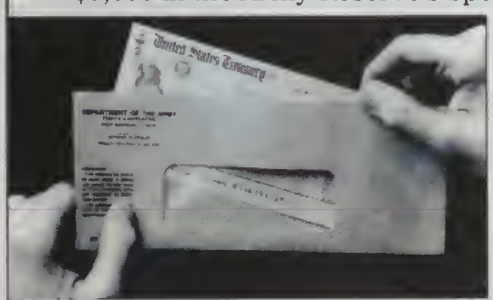

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A Call for Change

Wilma C. Light, MD

Should women physicians become involved in organized medicine? I would answer a definitive yes! Women physicians can bring a somewhat different viewpoint to organized medicine than our male colleagues, and the views of *all* members are important.

Women now comprise approximately 40 percent of the graduating class in Pennsylvania medical schools, and our needs must be addressed. However, most women physicians have to balance their time commitments to family and to medicine in different ratios than our male counterparts.

My first involvement with organized medicine came as a junior at Jefferson Medical College of Thomas Jefferson University. Seven students, including myself, were able to attend an AMA meeting that year, at which we discussed medical school curriculum.

I then moved out of state and did not really become active in the Pennsylvania Medical Society until 1985. At that time, I was president of the Pennsylvania Allergy Society and had been invited to the State Society to meet key personnel so that I would become more comfortable in interacting with the Society.

Then came my involvement with the Society's Hospital Medical Staff Section. Attending the AMA's Hospital Medical Staff Section meeting was an eye-opener for me. This was at a time when outside forces were starting to change the way we practice.

The "villain" changed each six months. Many times back then it was the Health Care Financing Administration (HCFA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Now, it is managed care and health system reform.

But what I took away from these meetings was the knowledge that we can learn from each other and the fact that we need to be united to deal with these large entities. If we don't defend quality patient care, no one else will. Government thinks bureaucracy will solve all problems, and managed care looks to the bottom line.

I have had the privilege of serving on the Society's Council on Membership—the last two years as chairperson. During the last year-and-a-half, I have also been working with the Task Force to Enhance Physician Involvement. Both the council and the task force have recommended changes to improve our Society, and the board has concurred (see page 38). The challenge now lies before the House of Delegates to take the ball and run with it.

"Although we have the strengths of a very talented professional staff and hard-working physician volunteers, change is needed."

Although we have the strengths of a very talented professional staff and hard-working physician volunteers, change is needed. If we leave the status quo, we will gradually lose relevancy to our changing membership, which will make us less effective in achieving our goals.

We need to become more focused, while not ignoring other concerns; we need to increase involvement of our rank and file, and streamline communications; and, most importantly, we need to become *membership driven!**

** Editor's Note:* ***Membership driven*** *is a term created by the Society's Task Force to Enhance Physician Involvement to describe an organization that responds to the needs of its entire membership, rather than to an individual's needs and wants. Proposed for the Society are focused priorities and a budgeting process reflective of those priorities.* *For more information, see pages 6 and 38.*

Dr. Light, a specialist in allergy and immunology from Latrobe, chairs the State Society's Council on Membership.

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Shifts, Blends, Mergers in Health Care:

A Progress Report—Special Insert, page 26a

Where We Are in:
Reform
Physician Integration
Provider Mergers
Capitation

Also in this issue:

Computers Blend into Medical Practice—page 12

Beware Silent PPOs—page 20

Drug Utilization Review Shifts Gears—page 34

An Interview with Our New President—page 14

John H. Hobart, MD
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OCTOBER 1994
VOLUME 97 • NUMBER 10

(Insert)
26a *Progress Report*

A supplement to Pennsylvania Medicine October 1994
REFORM Progress Report

As system reform efforts whither, real change is taking place in the health care marketplace. Over-viewed in this special insert are: reform and related Society activities, hospital mergers, physician integration, and capitation.

14 *Introducing the Next Leader*

John H. Hobart, MD, to be inaugurated president of the State Society this month, spoke with PENNSYLVANIA MEDICINE late this summer about the profession and its frustrations, reform, and the year to come.

Dr. Hobart

12 *Linking Up with MEDLINE®*

This first in a series introduces electronic medical libraries, accessible from homes or offices equipped with personal computers and telephones. Articles to follow will highlight more ways physicians can use computers in practice.

16 *End-of-Life Decision Making*

A web of controversy continues to surround the issue of discontinuing medical treatment. A look at international thinking offers other perspectives.

Related story:

28 *Promoting Living Wills*

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4 Late news at press time

Issues of Interest

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ANOTHER PMSLIC PROFILE

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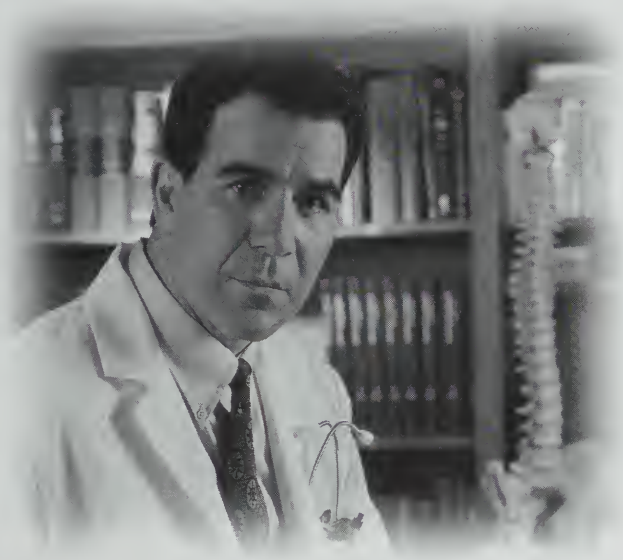

are lucky to have a resource like PMSLIC. I know. Early in my career I practiced in the Midwest. I saw colleagues get burned by a company promising the same medical liability protection for less money. I was pretty young, but luckily I didn't go with them. Unfortunately, my best friend, Phil, did. When his carrier went under, it looked as though a lot of good people would go down with it. Phil just got out by the skin of his teeth. A couple of our friends weren't so lucky. When I came to Pennsylvania, I checked out all my options. Know what? No company can match PMSLIC's record, or offer the same value-added services. Through the years, we've all heard many new carriers guarantee us big savings. But I can't see the value of saving a few dollars in the short run, if it means risking my future. Hey, if you don't believe me, give Phil a call. "

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MEDIGRAM

NATIONAL HEALTH REFORM DECLARED DEAD...FOR NOW: Senator George Mitchell (D-ME) on September 26 officially declared health system reform dead for the 103rd Congress. The senator blamed Republicans for standing in the way of the 60 votes needed to bring a bill to the floor. AMA Chair P. John Seward, MD, reacting in the *New York Times,* said, "Rather than blaming [anybody], we have to learn lessons from this exercise... The main reason that health system reform didn't pass is simply the complexity of the nation's health care system, and the complexity of the solutions proposed." He said comprehensive reform is still an appropriate goal, but that incremental steps may be more "doable." He concluded, "The status quo is not appropriate." As for the future of reform, White House reports indicate a strategy for the new year is already in the works, but word on the streets is that the focus may shift to the state level.

MEDICAID SURGICAL FEES INCREASE, CONs AT ISSUE: The Department of Public Welfare has announced a significant increase in reimbursement levels for selected surgical procedures performed in a physician's office. The increases are retroactive to July 1, 1994. In some cases, fees will increase from under $50 to more than $300 for a procedure, representing the department's acknowledgment of physicians' argument that overhead costs must be taken into account. *Note, however, that a Certificate of Need (CON) from the Department of Health may be required to provide certain surgical procedures, but indications are that virtually no CONs are being issued.* For information, call the Society at (800) 228-7823 or (717) 558-7750, extension 483 (fee increases) or extension 457 (CONs).

SENATE PASSES LIMITED LIABILITY BILL: The state Senate in late September unanimously passed Senate Bill 1059 to provide protections for limited liability partnerships. Prior to reaching the Senate, the bill was amended in committee to include Society language to protect physician corporate practices. The bill now moves to the House for consideration.

IMPLEMENTATION OF FEDERAL VACCINE PROGRAM ON HOLD: The Pennsylvania Departments of Public Welfare and Health on October 1 began operating the new, federally funded Vaccines for Children program; however, cancellation of a New Jersey vaccine distribution center has put vaccine distribution to *newly enrolled physicians* on hold. The program seeks to raise childhood immunization levels in the U.S. by providing federally purchased vaccines—at no cost to participating providers—for children in certain groups. According to the Department of Health, any provider already receiving vaccines will continue to do so.

CLIA HOTLINE TERMINATED: The Health Care Financing Administration (HCFA) has terminated its Clinical Laboratory Improvements Act (CLIA) hotline—formerly (410) 290-5850—effective September 30, 1994. Physicians needing information regarding CLIA certification, fees, inspections, etc., should call the Pennsylvania Department of Health Bureau of Laboratories at (610) 363-8500.

KEPRO, DYNCORP JOIN FORCES FOR NEW HCFA CONTRACT: The Keystone Peer Review Organization (KePRO) has received a five-year, $33 million contract from HCFA to become the Clinical Data Abstraction Center for HCFA's Central Zone, which includes 24 states and territories. KePRO will work with DynCorp, a technical services organization in York, to abstract hospital medical records. Operations will begin in January.

HOUSE TO RECONSIDER UNIFICATION, SOCIETY FOCUS: The Society's House of Delegates, at its annual meeting this month in Hershey, will reconsider its unification status with the AMA in response to a county-proposed bylaws change. Also, the House will consider a series of recommendations from the Task Force to Enhance Physician Involvement which seek to prioritize Society initiatives based on identified membership needs and to improve communication between the grassroots membership and leaders. Seventy-three resolutions have been submitted to the House for consideration; complete coverage will be included in the December issue of PENNSYLVANIA MEDICINE.

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Preserving Values: A Dying Craft?

John W. Mills, MD
Medical Editor

It has been observed that the recent interest in nutrition and health mania—along with a desire for "natural" products and "natural" ways of doing things, including recycling—stems from our hunger for purity and simplicity, and perhaps even more importantly, our longing for truth.

Equality and fairness could be easily added to our wish list, which really comes from our inner selves. Equality is guaranteed by our constitution; fairness is certainly intimated. Why do we long for the "self-evident" qualities in our daily life? Simply put, we are surrounded constantly by blatant dishonesty, manipulation, and hype beyond our control.

"It's no wonder we all seek some stability in our lives, some freedom from all the manipulation we constantly undergo via TV and radio."

Witness the tobacco companies. Hype plus! They have suppressed their own revealing studies and lied to us as well as to Congress. Research has proven the harmful effects of tobacco in any form, and as yet, regulation by our elected officials is a token attempt.

Money talks! The tobacco industry gave $2 million to members of Congress in the last election cycle, and now Phillip Morris is taking their cash to the people in California, where the company is sponsoring a "tobacco control" initiative on the smoking referendum on the November ballot. Instead of tough rules in force by many communities, there would be a weaker statewide standard *written* by Phillip Morris—all this according to Susan Estrich, a University of Southern California law professor.

Witness Congress. Several members presently are under indictment for criminal activity, most of it related to the House Post Office scandal. Congressman Dan Rostenkowski (D-IL), a most powerful representative who can still sway votes on health system reform, is accused of dishonesty and manipulation.

Looking closer to home, Charley Reese wrote an article, published in the *Punxsutawney Spirit*, on how to cure the American medical system. It was one of the most demeaning, vulgar essays I've ever read, suggesting that when a doctor loses a patient by death, the doctor should be killed in a similar manner. Even if it was written with tongue-in-cheek, it is totally unacceptable for publication—TRASH!

Then we have a physician and several employees of Care Mark in Minnesota indicted for fraud and abuse kickbacks in relation to sales of pharmaceuticals and durable medical equipment.

Consider, also, the chairman of the Congressional House Judiciary Committee, who is known for his disdain for tort reform.

All of the hype promoting RU486, the "morning after pill," should be carefully sifted through in light of the president of Hoechst's remarks when he said that RU486 would not have been developed if all of its side effects were known, according to Phyllis Zagano, an associate professor of communications at Boston University.

A note by a recent medical school graduate relates how the University of Virginia School of Medicine gave a "liberated" version of the Hippocratic Oath to the class to recite at graduation. A mockery, I'd say—just to be more politically correct!

It's no wonder we all seek some stability in our lives, some freedom from all the manipulation we constantly undergo via TV and radio—most of it spawned on "Madison Avenue."

As we approach our annual State Society House of Delegates meeting, we should seriously try for less hype and manipulation, and for more truth and honesty as we deal one-on-one—as officers, trustees, and staff—with our members, and they with us.

Mutual respect and the "Golden Rule" need to be consciously mastered and fine tuned. A fine vineyard and its wines are tangible and authentic—they both age well and have lasting value. Let's try to simulate nature.

As Sir Richard Steele noted: "There is not a more useful man in the commonwealth than a good physician, and by consequence, no worthier a person than he that uses his skill with generosity and compassion." ⬡

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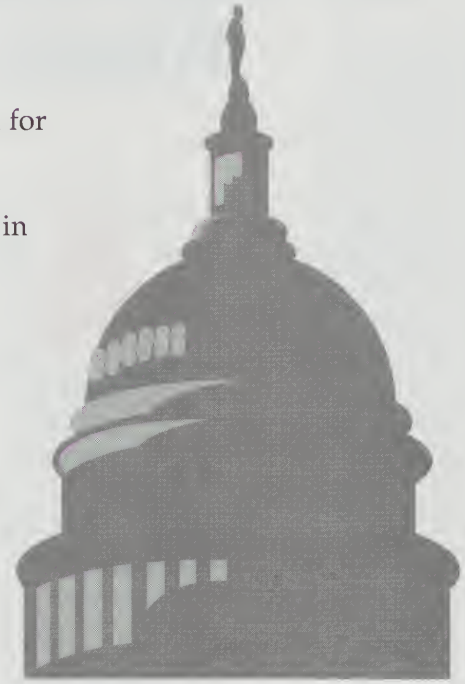
Dear Colleague:



Please join us in supporting the campaign of Rick Santorum for United States Senator from Pennsylvania.

As a Congressman, Rick Santorum has included physicians in his decision-making process, and has demonstrated his support for medicine's viewpoints in legislative forums. Rick has sought and continues to seek the advice of practicing physicians on behalf of our patients.

This will be a watershed year for our political future. Physicians must be involved, and we must support candidates who understand our concerns on:

- the quality of medical care
- access to care
- patient choice and control
- the importance of education and research
- meaningful liability reform
- antitrust reform
- physicians' leadership in managing the economics of medical care

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Giving Some Credit Where It's Due

Martin A. Murcek, MD

As I have traveled around Pennsylvania and neighboring states during my year as president of the Pennsylvania Medical Society, what has impressed me most is the big change in attitude among physicians since I began my term in 1993.

Last fall, everyone seemed resigned, but frustrated, about the prospect that Hillary and her "gang of 500" were about to bring us a real health care system crisis in the guise of "reform." Everyone I encountered felt that any changes wrought by the "Beltway crowd" would surely be changes for the worse.

In March of this year, a coalition of AMA leadership, 50 state medical society presidents, and other state society officers, converged on Washington, DC, in a show of strength. We heard from Senators Bob Dole (R-KS) and Phil Gramm (R-TX), and Representative Newt Gingrich (R-GA). Though no fans of "Clinton-care," they warned us that some sort of the legislation would be signed in the Rose Garden by mid-October, if only to allow Clinton to brag that he had delivered on a major campaign promise.

It is still possible that some sort of half-baked "health system reform" package might make it out of Congress and onto Clinton's desk, but Senator Dole said that prospect is "hanging by a thread."

There are many reasons for the big shift of opinion, but I believe the efforts of physicians to educate and motivate their patients to oppose haphazard "change for change's sake" was a big factor. Many of our patients contacted their legislators, and told them "Whatever you do, do it right, and don't do it in haste!"

I was appalled by the way groups like AARP sold themselves out. After meetings with AARP hierarchy, I felt that, despite the "company line," they were really committed to seeking rational, effective reform. When I realized that it was all double-talk, I felt that I had in some way let my patients and colleagues down.

It was heartening, however, to watch the AARP rank-and-file swing into action after the group's national leaders announced their support for the Gephardt plan: The AARP national headquarters switchboard was flooded by angry—and in some cases hostile—callers demanding that the support be withdrawn. Clinton's bunch and like-minded groups all got a real taste of "grassroots" politics at work. I'm sure many of them never expected it to happen like this.

> ***"...I believe the efforts of physicians to educate and motivate their patients...was a big factor."***

There are still too many physicians rushing to sign their careers away with some HMO or PPO because they are in fear of being left behind. PMSCO, the physicians' service organization of the Society formed in response to this unfortunate situation, has already entered contracts with seven physician groups; more are currently in negotiation.

While the threat of government meddling into quality American health care is on the wane, the rush to "managed care," being fostered by insurance companies, HMOs, and even hospitals battling for market share, is now our major concern.

The battle against socialized medicine will have to be fought again and again. Now, however, physicians have time to reason and reflect, calmly and deliberately, as our profession demands.

*A note from the president: Last month on this page, Pete Stark (D-CA) was mistakenly referred to as "the most physician-friendly member of Congress," instead of "the most physician-**un**friendly member..." as originally intended. We're still looking for the culprit who has befriended Mr. Stark.*

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LETTERS TO THE EDITOR

"TALE OF A TOENAIL" EVOKES RESPONSE

I am writing this letter in response to a letter published in your June 1994 issue from Dr. Edward A. Lottick under the banner "Tale of a Toenail" [page 10]. I am the president of the Pennsylvania Podiatric Medical Association, and his letter was forwarded to my attention.

There are several ways to approach the issues raised in Dr. Lottick's letter, one of which would be to remain silent. However, I feel that since the author chose to address the letter to Mrs. Clinton, style it in the guise of a valid comment on health system reform, publish the letter in his own publication, and subsequently bring his own letter to your attention, with the statement that he had received "some very positive local commentary," remaining silent would only serve to perpetuate, or worse, validate the misleading facts and erroneous conclusions that are contained in the letter.

First, the author indicates that he saw a Medicare patient in his office who complained of a very painful toe. His initial recommendation was that his patient should go home and "soak it." This would indicate that the doctor had proceeded to a treatment plan prior to even finding out, from a cursory history and physical, that the patient had already been soaking her foot for two weeks.

This small omission pales in comparison to the realization that the doctor gave that advice while looking at a toe on which he ultimately performed a total nail avulsion, obviously without the knowledge that "soaking" will have no curative effect. (It may be interesting to know what the doctor would have charged had the patient accepted his first plan of treatment.)

Second, the author indicates that he billed $125.00 for the procedure that he performed, and he was paid $21.46. This would indicate that the doctor miscoded his bill. Assuming that the author's description of the procedure was correct, then the correct code would have yielded a remittance of $45.83 (a fact verified by the doctor's Blue Shield Medicare Carrier).

Third, the author admits that when he thought that the reimbursement rate for this procedure was the paltry sum of $21.46, he felt that the next case such as this that he saw was complicated enough to refer to a specialist.

It was only when Dr. Lottick "...subsequently learned..." that the specialist received $400.00 for the procedure that he performed, that this matter assumes the mantle of an issue that lies at the heart of health care reform, and should be brought to the attention of the wife of President Clinton and all the members of the state medical society. It should be noted that this was a surgical procedure done by a well-trained surgeon and is a procedure that a "general practitioner" is not trained or qualified to perform.

It is impossible to tell from the letter how the author learned what the specialist received for whatever services he performed, and that is not the import of my response to the doctor's letter. The point that should be understood, in connection with the cases that are described by the doctor, is that podiatric physicians do not receive any more for Medicare procedures than medical doctors or osteopathic physicians. We do, through shear repetitive experience, code procedures correctly and try to respond to all of the referrals that we receive from other physicians with quality care, so that the patient is comfortable with our services and grateful to the referring physician.

It is most difficult, however, to read a broadside such as the one that was published in your magazine. It is this type of infighting and prejudicial presentation, based on half truths and misunderstandings, that perpetuates rancor within the body of all health care providers, at a time that we should all be acting as a united body in the face of the challenge of health system reform.

Dr. Lottick obviously trusted a colleague enough to make the referral of a patient to him or her. It is my hope that the misunderstandings that generated the ire reflected in his letter could be examined and explained so that the continuity of referrals between competent professionals could continue to their mutual benefit, and, ultimately, to the benefit of the patient.

Neal Kramer, DPM, President
Pennsylvania Podiatric Medical Association

Author's Response:
Dear Editor: Thank you for the opportunity to respond to the letter from Dr. Kramer. The original letter was intended to illustrate how a mindless bureaucracy functions or actually doesn't function. Other than that, I did not intend to step on anyone's toes.

Edward A. Lottick, MD
Kingston

QUESTIONING THE FOURTH SCOPE OF WORK

Somehow I thought it would be different.

KePRO officials told us that the Fourth Scope of Work would change the peer review process. Clinical relevance would replace frivolous detail. Physician education would replace disciplinary action. Logical thought would replace bureaucratic mentality. Well, maybe I expected too much.

I recently received a "Notice of Final DRG Change" from the "new" KePRO. It seems my discharge diagnosis was unacceptable. KePRO reviewers insisted on changing my diagnosis of "respiratory failure due to chronic obstructive pulmonary disease" to "chronic obstructive pulmonary disease with respiratory failure." Just think of it—$13.5 million allocated annually by the Health Care Financing Administration to KePRO so it can rearrange words on a page.

Sometimes the more things change, the more they stay the same.

Philip D. Carey, MD
Carlisle

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Remember—comments do not have to be negative! What has your county or State Society, or the AMA, done for you lately that you approve of? Please send letters to:

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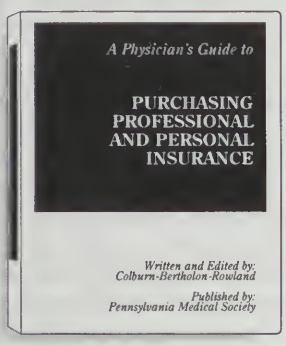

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Linking Up with MEDLINE®

Fred Baldwin

Pennsylvania physicians are joining the technology bandwagon, accessing medical databases from homes and offices equipped with personal computers and telephones. This article provides a brief introduction to these electronic libraries, focusing on one called MEDLINE®. A subsequent article will describe how to gain online (telephonic) access to these databases.

"We really couldn't figure out what was going on," says Richard Kleinert, MD, recalling a pediatrician's referral of a baby with multiple congenital problems, including near-blindness. "The two of us together did a real-time search, putting in all the different observations we'd made. It turns out that there were six other cases of this in the world. We were able to give the parents the option of seeing this other physician down at Johns Hopkins who had reported three of the other six cases. After calling, the parents decided that wasn't really necessary. The pediatrician here had made the correct diagnosis and knew how to treat their child. They didn't have to travel 500 miles to figure out what they should be doing."

Dr. Kleinert is an ophthalmologist on the staff of the Moshannon Valley Clinic, Geisinger Medical Group, Philipsburg, in western Pennsylvania. He's been doing online (telephonic) searches of medical computer databases for himself and his colleagues for nearly a decade. That makes him a veteran among an increasing number of physicians who are finding such searches to be easy, inexpensive, and, above all, useful.

"It's easier than flipping through a book, and you find a lot more on unusual topics," says Michael E. Kordek, MD, a staff physician at Geisinger's clinic in Dallas, with less than two years' experience in online searching. He can live with an occasional unsuccessful search, such as a recent one to determine whether patients who receive vaccines for hepatitis B may have protection against the disease even when tests show no antibodies. "At least you know you haven't overlooked something obvious."

Since the early 1970s, the National Library of Medicine (NLM), which is part of the National Institutes of Health, Bethesda, Maryland, has been developing a family of online databases collectively known as MEDLARS® (MEDical Literature Analysis and Retrieval System). Currently, MEDLARS contains more than 40 distinct databases, each a substantial library in its own right. Some have self-explanatory names like AIDSLINE® and CANCERLIT®. Others include DART® (Developmental and Reproductive Toxicology), which contains references on biological, chemical, and physical agents that may cause birth defects, and the recently added HSTAR® (Health Services Technology Assessment Research), which includes journal abstracts, technical papers, industry and trade publications, and newspaper articles.

The largest database within the MEDLARS system is MEDLINE, which might be thought of as a bigger, better, and more current version of the print reference, *Index Medicus*. MEDLINE contains well over seven million records from more than 3,800 international biomedical journals. If the original article included an abstract, it's in MEDLINE—true for about 70 percent of its current citations. MEDLINE also beats any conceivable print counterpart because it's updated weekly; over 30,000 new citations are added each month.

NLM reports that MEDLINE is searched approximately 20,000 times per day, increasingly by practicing physicians rather than academic researchers.

How useful are these databases, generally, to practicing physicians? Very useful, two recent studies suggest.

The June 23-30, 1993, issue of the *Journal of the American Medical Association* reported on a study involving 552 health professionals, over 70 percent of whom were MDs, who had used MEDLINE within the preceding year. In a series of 30-minute interviews, the researchers compiled information on 1,158 MED-

Mr. Baldwin, a contributing author from Carlisle, is currently co-authoring a book for Little, Brown & Co., with the working title, **Finding the Best Investment: A Consumer's Guide to Medical Information.**

LINE searches, 86 percent of which were reported as "effective."

The physicians interviewed reported several different uses for MEDLINE searches. The most important were: 1) identifying the most appropriate diagnostic test, 2) recognizing and properly diagnosing a medical problem or condition, 3) developing an appropriate treatment plan, and 4) actually implementing a treatment plan (e.g., identifying promising variations when the original treatment options were ineffective).

For example, one neurologist described a patient suspected of lupus, but with some atypical symptoms. A MEDLINE search to identify other vascular diseases led to a subsequent diagnosis of Sjogren's disease and a therapy of vigorous immunosuppression that would not otherwise have been used. Several physicians credited MEDLINE searches with enabling them to make life-saving decisions.

Asked why they used MEDLINE, the physicians said that textbooks could never be sufficiently current or specific to cover rare diseases, rare combinations of common diseases, or recent developments in diagnosis or therapy. Even those who had journals available found MEDLINE the fastest way to search for pertinent articles. Others cited MEDLINE's low cost (compared to journal subscriptions) and convenience. About half of those who did their own searching without relying on a librarian did so from their offices, over 40 percent searched from their homes, and fewer than 10 percent went to libraries.

A smaller study, more like a clinical trial than a survey, was conducted in Oregon during 1992-93. In this case, 48 searches were conducted by experienced medical librarians in Oregon on behalf of primary care physicians practicing in both urban and rural settings. After completing the searches, the librarians sent the physicians the full texts of selected articles.

For 58 percent of their questions, the physicians considered the information located to be "relevant." More significantly, 46 percent of the time they said they got a "clear answer" that almost as often "impacted patient care."

Although Drs. Kleinert and Kordek have access to the services of excellent medical librarians, they prefer to do their own searches, using a piece of software developed by NLM called GRATEFUL MED®. One reason, Dr. Kordek explains, is that searches involve some trial-and-error, and physicians can best judge for themselves how to narrow a search or switch search headings. Also, he adds, "I'm inquisitive and get satisfaction in finding an answer. Doing it myself may not be strictly necessary, but it's fun."

In fact, the librarians at the Geisinger Medical Center have actively encouraged physicians to learn to do their own searches and in 1990 and '91 sponsored, with NLM assistance, 68 demonstrations of the use of GRATEFUL MED throughout the largely rural area their clinics serve. They appeared before hospital staffs, county medical societies, and individual practices. Their report, recently published in the *Bulletin of Medical Libraries Association,* showed a significant increase in the number of physicians doing searches for themselves.

Nevertheless, most evidence suggests that Drs. Kleinert and Kordek are still in the vanguard—as few as 10 percent of practicing physicians use MEDLINE or related online information retrieval systems, according to some surveys. The main limitation of the MEDLARS databases is that they usually contain only abstracts and sometimes only citations. If you don't have easy access to a well-stocked medical library, you can order photocopies using a computer-based system known as LOANSOME DOC®, although this can be expensive.

What should physicians consider before trying to decide whether to connect to MEDLINE? "I think it's the only way to go," Dr. Kleinert concludes. "As the Nike commercial says, 'Just do it!' " ⬡

Editor's note: The next article in this series will include more information on GRATEFUL MED® and LOANSOME DOC ®.

UPMC Developing Teleradiology Network

The University of Pittsburgh Medical Center (UPMC) has received a $2.3 million contract from the National Library of Medicine to develop a teleradiology communications system, which will permit rapid transfer of high quality medical images for remote consultations.

Howard Yonas, MD, co-primary investigator in the contract, says the system "has the potential to improve short-term and long-term patient outcome, and have a positive impact on the cost of health care by avoiding unnecessary patient transfers and by expediting the necessary transfers."

Using specifically designed software—under development in collaboration with UPMC's Department of Radiology—and a telephone modem, physicians at six outlying hospitals in western Pennsylvania and Ohio will be able to quickly transmit high quality images of CT scans, X-rays, and MRIs. The images will be viewed by UPMC specialists—neurosurgeons, trauma surgeons, neurologists, radiologists, and critical care medicine physicians—on a high-resolution television screen.

Pennsylvania hospitals currently in the system include: Butler Memorial Hospital, Jameson Memorial Hospital in New Castle, and Latrobe Area Hospital.

Proud to be a Doctor

Maria T. Montesano
Assistant Managing Editor

John H. Hobart, MD, who will be inaugurated president of the State Society this month, talked with PENNSYLVANIA MEDICINE late this summer about the profession and its frustrations, reform, and the year to come.

Membership in organized medicine continues to be a point of contention among physicians nationwide. Some prefer not to belong, while others cite the "power in numbers" and available resources as reasons to belong. John H. Hobart, MD—who will be inaugurated as the State Society's 145th president on October 22—gives a very basic answer when asked why he believes in organized medicine: "I'm proud of being a doctor," he says.

Born in Montreal, Canada, Dr. Hobart is a naturalized U.S. citizen who wanted to be a doctor all along. "When I was 10 years old, I was going to be a neurosurgeon," he says, "but when I grew up I realized it wasn't for me." Instead, he chose urology, citing the "tremendous enthusiasm" and "marvelous teachings" of Cornelius Vermeulen, MD, whom he trained under at the University of Chicago Clinics.

"There aren't many times when medical students get up at 7:30 a.m. on Sunday to make rounds with someone," Dr. Hobart says, "but they would with Dr. Vermeulen. There is no question that it was his contagious enthusiasm for urology that hooked me into it."

Following his rotating internship at the clinics, Dr. Hobart worked as a fellow in the Harrison Department of Surgical Research, University of Pennsylvania. He then served as a captain in the U.S. Army Medical Corps for two years, before completing his residency at Columbia-Presbyterian Medical Center, New York, New York. He was certified in urology in 1964 and has practiced in the Easton area ever since. He and his wife, Joan, have five grown children.

Frustrating, yet satisfying

Being a physician is many things, according to Dr. Hobart: "Interesting, exciting, satisfying...." But he also admits some personal frustrations, mainly "the extraordinary noncompliance of so many patients—the diabetic who insists on weighing 300 pounds, the smoker whose coughing his or her lungs out, the drunkard whose liver is rapidly disappearing—the people who essentially won't look after themselves. Everywhere you turn, you find some different kind of nihilism in people's attitudes."

He says limited resources is a second frustration. "It's fine to say we have an indigent care program, but when you start trying to use the [Medical Assistance] program, it's full of cracks for patients to fall through." He calls the system "second rate"; and while he says the two frustra-

JOHN H. HOBART, MD
145TH STATE SOCIETY PRESIDENT

BORN: October 20, 1929

MEDICAL SCHOOL: College of Physicians and Surgeons, Columbia University, New York

SPECIALTY: Urology

CURRENT POSITIONS: Director of surgery and attending urologist, Easton Hospital; clinical assistant professor, Hahnemann University, Philadelphia

STATE SOCIETY SERVICE HIGHLIGHTS: Former chairman/former secretary, Board of Trustees; delegate, State Society House of Delegates; director and vice chairman of the board, Pennsylvania Medical Society Liability Insurance Company

tions "may well go together," he stresses that "noncompliance is not limited to the indigent population."

These frustrations are also prominent in his discussion of health system reform. "The comment I've heard repeatedly from my non-medical friends is, 'I would like to see the indigent receive care...the needy looked after,' " Dr. Hobart says. But that same group is not particularly anxious to give up anything. "We have a pretty good system right now. Let's not mess up the 85 percent that are doing pretty well to address the other 15 percent, especially when so many of the rest have *chosen* different lifestyles—lifestyles of 'I don't insure my health, I don't insure my car,' etc."

Instead, he advocates instituting portions of health system reform, such as medical liability reform and antitrust relief, but acknowledges that the system is far from perfect. He stresses that physicians—and more importantly, the federation of medicine—need to take the lead in such reform.

At bat for patients

Dr. Hobart joined his county society, the State Society, and the AMA in 1962, and though he has been active throughout the years as a member of several committees and task forces, he says he never really thought about being president. Instead, he sought to serve his peers as a district trustee, a role he assumed in 1983 and held until last year. He has also served as secretary of the State Society and chairman of the board for three years—a position he says allows one to be the best trustee that he or she can be.

He has also been instrumental in the workings of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) since its inception in 1978. He has been a director for 16 years and also serves as vice chairman of the board, chairman of the Claims Committee, and a member of the Executive and Finance committees.

"My experiences at PMSLIC have been most rewarding," he says, "because basically we have been able to do a good job doing what we started out to do: Providing physician-oriented professional liability insurance at reasonable rates." Dr. Hobart also credits his PMSLIC experiences as having taught him "a lot more" about medicine. "I've also become far more conversant with the function of the Society and it's organization"—knowledge that is sure to come in handy to him as president.

His pursuit of the presidency, then, was the result of suggestions from his friends and colleagues, he says, and since he "had nothing but very positive feelings" about the organization and his peers, he admits it didn't take a lot of arm twisting to get him to run.

Dr. Hobart believes bettering the health and well-being of the profession and its patients is the Society's main challenge, and the key to doing that well, he says, is two-way communication: "The Society communicating to members, *as well as* the members communicating to the Society!"

But that can be "awfully hard," he admits honestly. "We've had a number of major victories in the last several months through the efforts of the State Society. I believe the average member is not fully aware of them, much less the nonmember physicians who will benefit from them just as much as the members whose dues, sweat, and blood have gone into the accomplishment."

"I was talking earlier about noncompliance and unrealistic patients, but," he adds, "you also must address the issue of the unrealistic physician in terms of what he or she is going to have to *do* to be successful in the profession."

"I'm proud of being a doctor," Dr. Hobart continues. "My little niche of the system has many flaws in it; everyone's does. But if we don't have an organization to represent our combined interests...the profession is not going to thrive, [and] if, through my involvement in the Society, I can help make my profession a better one, or make it a profession that is more useful to the people, I'm delighted."

Taking the lead

As president, Dr. Hobart says he is most looking forward to meeting more of his colleagues. "I know a lot of physicians in Pennsylvania, and I'm looking forward to the opportunity to get to know even more and to visit some of our colleagues in neighboring states."

He will be inaugurated, in what he describes as "a low-key ceremony," at the end of the House session on October 22 in Hershey. Though he didn't offer any insights into his inaugural remarks, Dr. Hobart did give the following charge to physicians:

"These are times of change, and medicine continues to be under challenges, threats, and pressures which it had not been in the past. It's a time for all of us to acknowledge our strengths as well as our weaknesses and present a unified front to help our patients. No one cares about a sick person any more, except perhaps the family and hopefully the physician...Someone has to be supportive of our patients, and someone has to be supportive of our profession. If it's not us, who is it going to be?" ⬡

"I believe the average member is not fully aware of [recent Society victories], much less the nonmember physicians who will benefit from them just as much as the members whose dues, sweat, and blood have gone into the accomplishment."

—John H. Hobart, MD

End-of-Life Decision Making and Developing International Law

Leo Uzych, JD, MPH

Physicians may increasingly find themselves enmeshed in the web of controversy associated with the propriety of discontinuing treatment, particularly when the treatment may provide no discernible therapeutic benefit to an incompetent patient. A look at international thinking on this issue offers other perspectives.

More than 80 percent of Americans 65 or older die in hospitals or nursing homes, and an estimated 70 percent of these persons die after a decision to forgo life-sustaining medical treatment has been reached.[1] Although the thorny issues arising from end-of-life treatment decisions may be medical, ethical, and moral in nature, they are also fettered by indissoluble bonds to the legal realm.

Over the past 20 years, a body of pertinent case law has grown in the U.S., spawned originally by the landmark case in 1976 involving Karen Quinlan and reaching, more recently, to the 1990 Supreme Court case of *Cruzan v. Director, Missouri Department of Health.* Continued, rapid advances in medical technology, however, have contributed to a blurring of any lines of sharp demarcation separating affected concerns, including the principle of the sanctity of life, the principle of self-determination, and the patient's right to privacy and autonomy. And underlying, unresolved issues may seek refuge in courtrooms and legislatures.

Physicians charged with treating incompetent patients at the end of life may unwittingly find themselves crossing the Rubicon and entering the terrain of treatment decisions arguably violative of extant laws.

Courts in some of the commonwealth nations have recently adjudicated cases pertaining to the treatment of incompetent patients. It may be instructive for concerned Americans to open their eyes to see how other common law nations have sought to resolve contentious issues affecting the end-of-life treatment of the incompetent patient.

Mr. Uzych is an attorney, specializing in health law, based in Wallingford.

New Zealand

A case decided recently by the New Zealand High Court, titled *Auckland Area Health Board v. Attorney General,*[2] shines light in the area of the incompetent patient's right to die. This case, in which the court ultimately ordered the withdrawal of artificial ventilatory support from a patient suffering severely from Guillain-Barre syndrome, represents the first instance in which a court in New Zealand was directly confronted with the contentious issue of the "right to die" of an incompetent patient.

As described in the court's decision, the patient—identified simply as "Mr. L"—was not "brain dead," albeit denervated and in a "locked in" and "locked out" state, and, therefore, "completely dependent" on artificial ventilatory support. The prognosis was "hopeless." Discontinuation of artificial ventilation would result in immediate cardiac arrest and the quick, painless death of Mr. L; with the ventilatory support, he could survive indefinitely.

The treating physicians, with the "full support" of Mrs. L, wished to withdraw the ventilatory support, given the determination that the patient's condition would not improve and the belief that there was no therapeutic or medical benefit in continuing the artificial ventilation. The physicians, however, were fearful of acting on their decision, because of acute concern over the possibility of prosecution for murder or manslaughter, pursuant to the strictures of a New Zealand law, called the Crimes Act 1961. Therefore, they sought a declaration from the court stating that what they wished to do was not unlawful.

The provision of the foregoing law essentially imposes a "legal duty" on a physician to extend the "necessaries of life" to dependent patients under their care, and further imposes criminal re-

sponsibility upon a doctor for omitting, without "lawful excuses," to honor such duty, if the omission causes harm to the patient. The judge's decision states that the provision of artificial respiration may be regarded as a "necessary of life" if required to "prevent, cure, or alleviate" a disease endangering the patient's health. If the patient is surviving only by virtue of mechanical means and is "beyond recovery," however, then the use of a ventilator cannot properly be construed as a necessary of life.

Given extant circumstances in Mr. L's case, a life support system serves "no purpose" and cannot properly be regarded as a necessary of life. Further, even if the treating physicians had a legal duty to provide ventilatory support to Mr. L as a necessary of life, it would not be unlawful to discontinue the artificial ventilation if the discontinuance accorded with "good medical practice."

As envisioned by the judge, this generic term encompasses: the doctor's bona fide intent to serve the patient's "best interests"; attachment to "prevailing medical standards"; consultation with the medical profession's "recognized ethical body"; and concurrence of the patient's family. The judge opined that in Mr. L's case, there was assurance of "good medical practice."

The judge's formulation of the contours of good medical practice is well conceived, as far as it travels. But some commentators may look askance at the design because it is oddly bereft of overt mention of the wishes of the affected patient.[3-4] As perceived by the New Zealand judge, what is involved is medical treatment in accordance with the "doctor's best judgment" as to what is in the best interests of the patient. Yet, particularly in a matter involving literally life and death, wouldn't it be wise and eminently desirable to garner, or attempt at least to garner, the wishes of the patient whose life will end if life support is withdrawn?

The lack of meticulous attention to patient self-determination, revealed by the New Zealand decision, is strikingly at variance with the body of pertinent case law which has developed in America.[5]

England

Other commonwealth courts, as well, have recently had occasion to address vexing issues associated with the withdrawal of care from incompetent patients.

In England, the House of Lords, the highest court in the country's legal system, recently broached this area, in a case titled *Airedale NHS Trust v. Bland.*[6] The so-called law lords considered the legality of withdrawing artificial hydration and nutrition in the case of a young man, named Anthony Bland, suffering from a condition known as a persistent vegetative state (PVS). Their lordships approved allowing physicians to withdraw artificial feedings, and the patient succumbed a few days after the equipment was withdrawn. This case marks the first time an English court has focused attention pointedly on the question of particular circumstances, if any, which may empower a physician to lawfully discontinue life-sustaining equipment, including nutrition and hydration.

"The lack of meticulous attention to patient self-determination, revealed by the New Zealand decision, is strikingly at variance with the body of pertinent case law which has developed in America."

The patient was injured in a disaster occurring at a football ground, suffering a severe crushed chest injury, giving vent to hypoxia brain damage. Although the brain stem of the patient was intact, prolonged oxygen deprivation had caused irreparable damage to the cerebral cortex. No hope of recovery or improvement in the patient's condition was maintained by his doctors. The patient had not, before the disaster, provided any indication of his wishes if he should ever find himself in such a condition.

Armed with the support of the patient's family and doctors, the authority responsible for the hospital where the patient was being treated sought declarations regarding his future medical care, including a →

declaration empowering them to lawfully discontinue all life-sustaining treatment and support measures intended to keep the patient alive in his PVS, encompassing the termination of ventilation, nutrition, and hydration by artificial means.

Because Anthony Bland was incapable of taking any steps in the court proceedings, the official solicitor of the supreme court was appointed to act as his guardian ad item. This mechanism allowed the rights of the insensate patient to be argued as the case winded its way through the various stages of appeal, coming to rest, finally, in the House of Lords, where their lordships dismissed an appeal of an earlier grant of the declarations sought. In this respect, at least, the English case can be contrasted with the New Zealand case, where no one really spoke for Mr. L or argued for his rights.[7]

The pivotal legal issue identified by their lordships related to the legal duty of the doctor.[8] The law lords categorized the withdrawal of hydration and nutrition as an "omission," to provide care, rather than as an act, and then moved on to consider whether the doctors' conduct, albeit an omission, constituted a breach of their duty to the patient. The law lords, in the latter vein, opined that the doctors were under a duty to act in the patient's "best interests." If continued treatment was not in the "best interests" of Anthony Bland, then their conduct would not represent a breach of duty. Given the permanently insensate condition of the patient, the law lords concluded that Bland could not benefit from continued treatment.

Although the law lords sought to clarify the state of the law affecting the care of a PVS patient, issues and uncertainty persist concerning the withdrawal of care from patients who are incompetent, albeit not in a PVS. The line of demarcation between patients who are insensate and those who are not is also not clear.

How would an English court, for example, perceive Mr. L? On the one hand, he is arguably not insensate to the extent that his higher brain can still function; on the other hand, in light of his "locked in" and "locked out" status, he arguably could be described as insensate.

Thoughts for the future

In America, rather profuse legislation has been crafted, enabling competent persons to pen so-called "advance directives," intended broadly to structure end-of-life decisions, and medical care generally, if the maker should subsequently become incompetent and fall ill. Virtually all of the states now have laws authorizing proxy directives, such as durable powers-of-attorney for health care, and instructional directives, such as living wills.

There is, however, a paucity of data concerning the actual efficacy of advance directives. As medical technology continues its rapid, inexorable march, the chasm between "old law" and "new medicine" will likely widen. Attendant issues, with roots extending to medicine, as well as law, ethics, and social policy, will have to be fleshed out. Ultimately, wisely crafted reform measures, affecting care of the incompetent patient, will come to pass only if the widely divergent views in this issue-laden area are sifted through the strainer of professional and public debate.

Editor's Note: At press time, the State Society's Board of Trustees had approved publication of a "Physician Living Will Information Kit" developed by the Society's Commission on Bioethics. The kit is to include professional viewpoints concerning malpractice issues, guidelines, terminology, and other resources. More information on availability of the kit will be published in upcoming issues.

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Living Will Brochures Available

See page 19 for information about ordering a brochure for patients, *Dignity in Life, Dignity in Death,* developed by your State Society.

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The Society's Communications and Public Affairs Division continues to make the "Dignity in Life, Dignity in Death" living will brochure available for members to distribute to their patients. As a member, you are entitled to 100 free copies of the brochure, and additional quantities are available at a modest cost. For a limited time, an additional 25 copies are offered as a bonus. If you have not yet ordered your free brochures, you may request 125 at no cost. If you have received your free supply, you are entitled to an additional 25 at no cost.

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Physicians May Be Vulnerable To Silent PPOs

Michael L. Ile, JD

The AMA is urging its members to take the lead in eliminating a new insurance industry practice which is not only illegal, but is also costing physicians and hospitals an enormous amount of money each year.

The American Medical Association (AMA) has uncovered a widespread practice in the insurance industry that has cost physicians and hospitals hundreds of thousands, perhaps millions, of dollars. Any doctor or hospital signing a preferred provider organization (PPO) contract is vulnerable to this "silent PPO" scheme, in which insurance companies use brokers to avail themselves of PPO discounts to which they are not entitled. Vigilance on the part of providers is essential to eliminate this practice.

Background

Normally, a PPO contract reflects a straightforward exchange of bargains. The provider agrees to accept discounted fees in order to be designated a "preferred provider" by the insurance plan. Beneficiaries who choose a PPO plan are given substantial financial incentives to select preferred providers, and they usually receive a directory to help them do so. The PPO may pay 90 percent of the bill of a preferred provider, but only 70 percent of the bill if a beneficiary selects a non-plan provider. By comparison, traditional indemnity plans typically pay 80 percent of a provider's bill.

The financial incentives of PPOs are necessary to attract beneficiaries to a plan that will restrict, even to a relatively minor degree, their choice of providers. In fact, PPOs often serve as transitional vehicles for patients unaccustomed to managed care plans. Providers are motivated to join PPOs because they expect the PPOs' financial incentives and directories to steer more patients to them. There are currently over 650 corporate PPOs operating in the United States.

Mr. Ile is the AMA's health law division counsel.

How silent PPOs work

Given the fundamental nature of legitimate PPOs, the term "silent PPO" seems oxymoronic. How can providers be "preferred" if their identity is secret? The answer is that silent PPOs are not PPOs at all. They are a mechanism through which insurance companies make misrepresentations and take discounts to which they are not entitled. This happens thousands of times each day.

Here's how it works. (The example involves a hospital, but physicians are vulnerable in precisely the same way.) Suppose that Fred is enrolled in an insurance company indemnity plan. Fred has chosen the indemnity plan, with its higher premiums, because he wants no restriction on the physicians or hospitals he may use. Fred becomes ill and is hospitalized. When Fred is admitted, Hospital A calls the insurance company and verifies that Fred is covered by an indemnity plan that pays 80 percent of Fred's bills up to $5,000, and 100 percent above that amount. After Fred is released, Hospital A sends a bill to Fred's insurance company and, as Fred is in an indemnity plan, bills at full price with no discount.

The insurance company would rather not pay full price to Hospital A. It therefore calls a broker who has access to the list of providers and discount levels for several legitimate PPOs. (How the broker acquired this information is discussed below.) The broker searches its rosters and discovers that Hospital A has signed a contract with PPO X that calls for a 25 percent discount. The broker sends a fax to the insurance company with this information.

The insurance company then recalculates Hospital A's bill for Fred, taking 25 percent off the original bill. The new bill, called an Explanation of Benefits (EOB) form, will have a notation specifically referring to the PPO X discount as the reason for the lower price. Upon receiving this document, the accounting department at Hospital A verifies that the hospital has a current contract with PPO X.

Unless the hospital searches Fred's admission records, such as the photocopy of his insurance card, it will be unaware that Fred is not a member of PPO X (or any other PPO for that matter). The hospital will grant a discount that it is not contractually bound to give, in effect extending to the insurance company the discount that it negotiated with PPO X. That discount was intended to apply to a defined group of beneficiaries: the enrollees in PPO X.

Hospital A could prevent the silent PPO from operating by comparing the insurance company EOB with its verification of Fred's coverage. However, the administrative costs of manually checking every claim are prohibitive. Not all providers, especially physicians, have the information management systems needed to cross check records efficiently. That is no longer true. As discussed below, providers must change their way of doing business with insurers.

Why would PPO X permit the insurance company and broker to use its roster of providers? Money. The insurance company pays the broker 30 percent of the amount "saved" on Fred's bill for providing the information on PPO X. The broker splits its fee with PPO X for the use of its roster of providers. The transaction is simple. All that is required is two telephone calls or faxes. Costs are near zero, and the savings can be huge: 20 percent to 30 percent or more of a multi-thousand dollar bill. But because the transaction costs are so low, this process can be, and is, used for relatively small claims. With very little effort, PPOs and brokers can make substantial profits by completing a high volume of transactions.

Numerically, the example above would look like this:

INDEMNITY	SILENT PPO
Total bill $5,000	Total bill $5,000
Insurer pays hospital $4,000	Insurer pays hospital $3,000
	Insurer pays broker $300
Fred pays $1,000	Fred pays $1,000
Hospital gets $5,000	Hospital gets $4,000
	Broker gets $150
	PPO X gets $150

Does this silent PPO benefit the patient? No. Fred is billed for 20 percent of the original bill by Hospital A, just as his indemnity plan provides. Unless Hospital A discovers the insurance company misrepresentation and rejects its attempt to take a discount, the insurance company will pay less than the 80 percent of the total bill that it bargained with Fred to pay.

Meanwhile, the insurance company will not share its "savings" with Fred. Fred is paying indemnity plan premiums and not getting the benefits he bargained for. The PPO is "silent" because Fred doesn't know that he's in one. And he's not.

Does the silent PPO benefit Hospital A? No. Hospital A agreed to discount its prices to PPO X in exchange for its designation as a preferred provider. That agreement had no effect on Fred's decision to select Hospital A. Fred had no financial incentive to go to Hospital A, because Fred is not a member of PPO X. He has paid for indemnity coverage which allows him to select any hospital. He is under no financial incentives at all, and he has never seen a directory of preferred providers for PPO X. He chose Hospital A for personal, not economic, reasons.

By selling information about Hospital A's discount to Fred's insurance company, PPO X is striking at the heart of the bargain it reached with Hospital A. Hospital A offered the discount in exchange for a promise—that a defined group of patients (the members of PPO X) would be encouraged to use Hospital A.

Fred is neither a member of that group nor encouraged by PPO X in any way to use Hospital A. Nevertheless, the insurance company may succeed in gaining access to this discount by falsely stating (or implying) that Fred is a member of PPO X. After all, the insurance company is entitled to a discount under Hospital A's contract with PPO X only if Fred is a member of PPO X.

Who does the silent PPO benefit? The insurance company, the broker, and PPO X. To be sure, the insurance industry claims that providers are well aware of silent—or non-directed—PPOs, and that PPO contracts with providers generally permit the sale of discounts to other payers. The AMA has a different view.

"Who does the silent PPO benefit? The insurance company, the broker, and PPO X."

Recommendations

Silent PPOs are very common. Silent PPO brokers' marketing materials set forth quite clearly how they operate. This is a →

widespread practice in the insurance industry, and providers must take steps to protect themselves from the loss of income to which they are entitled.

The silent PPO approach is applied not only with indemnity patients, but also with patients who are members of a legitimate PPO but use a non-preferred provider. In fact, any situation in which an insurance company is facing the prospect of paying a non-discounted claim is ripe for silent PPO treatment. Thus, every physician and hospital with a PPO contract should:

1) Review the terms of each contract to assure that the PPO is not permitted to sell the discount to other plans, and to verify that the PPO is obligated to use financial incentives, directories, and the like to steer patients to preferred providers. Do not sign a contract that permits silent PPOs to use your discount unless you are prepared to discount all of your business.

2) Audit your files to assure that the discounts you have given are appropriate. Reject any attempt to secure a discount for a patient who is not a member of a PPO with whom you have contracted. Compare the representation on the insurance company EOB form with the information you received in verifying coverage at the time of initial treatment of the patient.

You can also call the insurance company to verify the terms of the patient's coverage after you receive an EOB that does not conform to information previously supplied by the patient, for example, where the patient's insurance card makes no mention of a PPO but the EOB indicates a PPO discount. The insurance company telephone clerks will be amazingly forthright about the terms of the patient's coverage.

Do not assume that the insurance company is entitled to every discount it seeks.

3) Institute a mechanism to identify patients who are entitled to a discount, so that claims which incorporate an inappropriate discount are flagged. Silent PPOs are successful because providers trust the representations made by insurers. You may no longer safely do so.

The AMA believes silent PPOs constitute fraud on the provider community, and we have brought this matter to the attention of law enforcement agencies. At the same time, providers must take the initiative and protect themselves from this practice. ✪

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May 10, 1995

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Friday-Sunday
February 10-12, 1995
Danville Days Inn

Contemporary Issues in Internal Medicine
Wednesday
March 8, 1995

Cutaneous Surgery
Friday
March 17, 1995

Advances in Dermatology
Wednesday
April 5, 1995

Annual Thoracic Medicine Seminar
Wednesday
April 19, 1995

Primary Supportive Care for the Cancer Patient
Friday
April 28, 1995

9th Annual Sight Loss Support Group Meeting
Wednesday
May 3, 1995
Danville Days Inn

Acute Renal Failure
Wednesday
May 17, 1995

Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

717-271-6692 or 1-800-272-6692

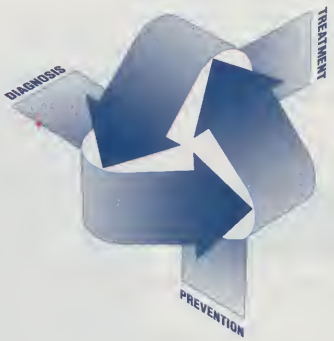
Geisinger

As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, Geisinger designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, at 1-800-272-6692. There is a 24-hour answering service available. You may also write to her at 100 North Academy Avenue, Danville, PA 17822-1350.

LEARN WITH THE LEADERS

The American Society of Hypertension Announces a series of half-day symposia for the office-based physician

What To Do About Hypertension in 1995



October 29, 1994
Lawrence R. Krakoff, MD, *Chairman*
Le Parker Meridien Hotel New York, New York

November 5, 1994
Michael A. Weber, MD, *Chairman*
Hotel Nikko at Beverly Hills Los Angeles, California

Topics to include:

Common sense evaluation and workup of hypertensive patients

The insulin-resistance/hypertension syndrome: Is it real and relevant?

The renin system: Measuring and treating it to decrease heart attack, heart failure, and kidney failure

21st Century treatment of hypertension and high cardiovascular risk: An alphabetic approach: A through E

Pacticipating Faculty:

Lawrence R. Krakoff, MD
Jon D. Blumenfeld, MD
Robert A. Phillips, MD, PhD
Thomas G. Pickering, MD, PhD
Michael A. Weber, MD
Henry R. Black, MD
Michael L. Tuck, MD
Vincent DeQuattro, MD

For information call
The American Society of Hypertension at 212/644-0650.

The American Society of Hypertension designates this Continuing Medical Education activity for 4 hours in Category 1 of the Physician's Recognition Award of The American Medical Association.

This program has been reviewed and is acceptable for 3.75 Prescribed hours by the American Academy of Family Physicians.

This program is supported in part through an educational grant from Du Pont Pharma and Merck U.S. Human Health.

DOCTORS APPEAL EXCLUSION FROM PREMIERBLUE

Approximately 2,000 physicians have appealed Pennsylvania Blue Shield's decision to exclude them from PremierBlue, the company's new insurance network developed to replace its traditional participating doctor (par-doctor) network.

Selective contracting of physicians is one of the predominant differences between the two networks. PremierBlue selectively contracts according to criteria overviewed in "Special Update: PremierBlue," a supplement to PENNSYLVANIA MEDICINE published by the State Society in September 1993—just prior to program implementation. To date, approximately 10 percent of all health care professionals—including physicians and non-physician providers—who have applied for PremierBlue membership have been denied, according to Blue Shield.

Reasons given for denial include:

- lack of board certification/ insufficient continuing medical education (CME) credits submitted (37 percent);
- lack of board certification/no CME credits submitted (20 percent);
- unacceptable historical practice pattern (12 percent);
- lack of appropriate malpractice coverage/unacceptable malpractice history (9 percent);
- lack of hospital privileges (8 percent);
- lack of Pennsylvania license (1 percent); and
- other (13 percent).

The Society encourages deferred applicants to use the appeals process, also outlined in the September 1993 supplement. The Blue Shield Enabling Act requires that initial appeals be made to Blue Shield, before physicians can take their cases to the state or the courts.

Members with questions about PremierBlue can call the Society's Reimbursement Resource Program at (800) 228-7823.

PROPOSED HCFA RULE WOULD REFINE GPCIs

The State Society in August commented on a Proposed Rule issued by the Health Care Financing Administration (HCFA) that would refine the geographic practice cost indices (GPCIs), change relative value units, and revise a number of payment policies for specific physician services.

Analysis finds faults

In an analysis, the AMA says that while HCFA proposes to allow separate payment for care plan oversight services, the proposed coverage policy is very restrictive and rejects the new CPT codes adopted for these services, as well as the work relative value recommendations developed by the AMA/Specialty Society RVS Update Committee.

Coverage would be extended only to services provided to patients receiving Medicare-covered home health care services. Further, HCFA would not recognize care plan oversight as a new service and would reduce relative values across all physician services to meet budget-neutral requirements.

In revising the GPCIs, HCFA proposes to use data from the 1990 census on earnings and expanded professional liability data, but would continue to use Housing and Urban Development (HUD) fair market rental data for residential rents as a proxy for physician office rents. The AMA notes that most of the changes under the new GPCIs would be "quite small" and would be phased in over two years.

Other proposed changes include:

- revising payment for multiple surgeries by increasing—from 25 percent to 50 percent—the standard percentage for the third through fifth procedures,
- extending the site-of-service differential to an additional 230 procedures, and
- including payment for antigens prepared by physicians under the payment schedule.

Society responds to HCFA

In a letter to HCFA, State Society President Martin A. Murcek, MD, suggested that HCFA:

1) refine the GPCIs by replacing "proxy" data with current data on physicians' actual costs;

2) accept the recommendations of the AMA/Specialty Society RVS Update Committee for the work relative value units for carrier-priced and non-Medicare codes; and

3) strengthen the proposed payment policy on care plan oversight by implementing the policy with the two existing CPT care plan oversight codes, applying the policy to all sites and circumstances covered by the CPT codes, valuing these services according to the RVS committee's recommendations, and not applying budget neutrality constraints to these new services.

A summary of *all* comments received by HCFA is expected to be published in a future edition of the *Federal Register.* Look for updates on this issue in future Society publications.

BUREAU ISSUES NEW DISABILITY FEE SCHEDULE

The Bureau of Disability Determination, Department of Labor and Industry, has announced implementation of a new fee schedule, effective May 9, 1994.

The fee schedule reflects a number of increases for physicians, including an increase in reimbursement from $75 to $100 for the various specialty disability examinations. The department had previously increased from $15 to $25 the fee paid to complete requests for medical records.

These announced fee increases are the result of numerous Pennsylvania Medical Society interactions with the bureau, as well as the development of a set of "principles" regarding services to be reimbursed by the bureau.

For further information, or to receive a copy of the latest fee schedule, please call the Society's Department of Medical Economics at (800) 228-7823 or (717) 558-7750.

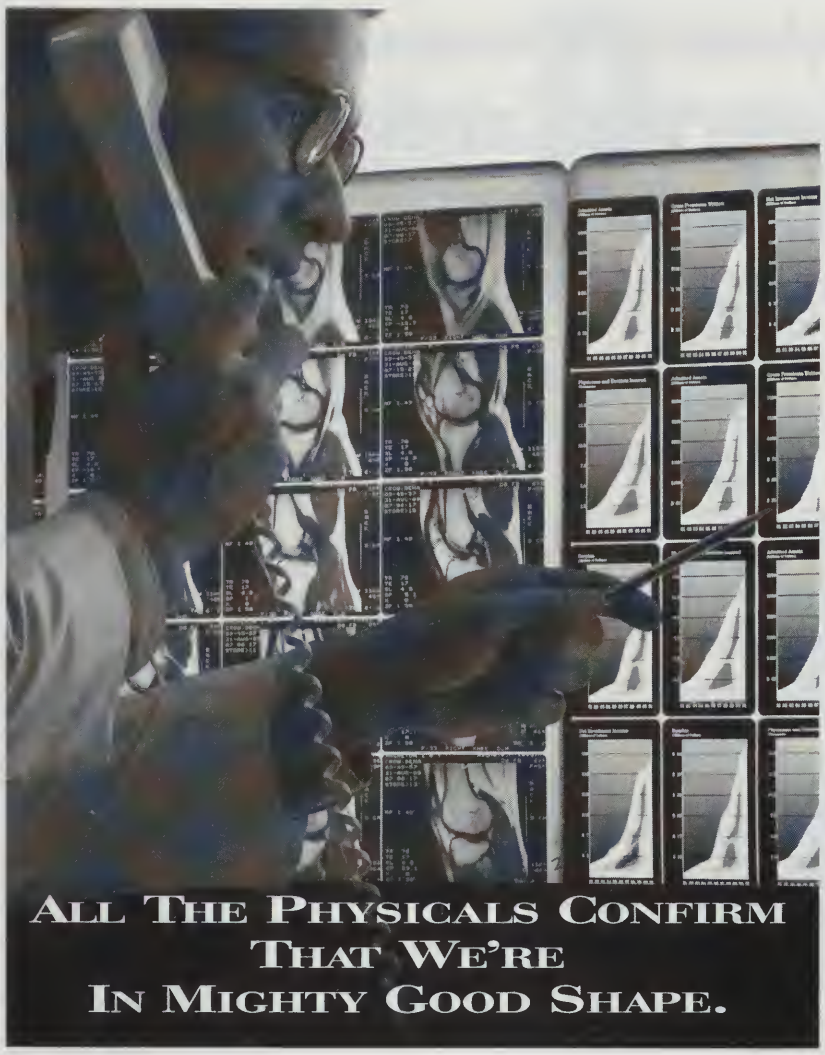
MEDICARE PROGRAM CHANGING NAME

Pennsylvania Blue Shield has announced that as of January 1, 1995, its Medicare Part B program will begin operating under a new name—**Xact Medicare Services.**

The change is being made to reduce confusion for out-of-state beneficiaries and health care professionals who have mistaken their local Blue Cross and Blue Shield plan for the plan that administers their Medicare benefits.

Customer service numbers will remain the same:

- For recipients, (800) 382-1274.
- For health care professionals, (717) 763-5700.



ALL THE PHYSICALS CONFIRM THAT WE'RE IN MIGHTY GOOD SHAPE.

Examine our performance and you'll agree. Membership was up again last year, passing 17,000. Total premiums written surpassed $165 million. Policyholders' surplus in excess of $50 million. Healthy numbers, confirmed by insurance auditors, and an A.M. Best Rating of B+(Very Good). We have a strong financial position, increasing market share and competitive pricing. A solid foundation for your future. For more information, call us at 1-800-228-2335.

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Pennsylvania's Gubernatorial Race:

Where the Candidates Stand on Health Care

At first glance, gubernatorial candidates Tom Ridge (R) and Mark Singel (D) appear to be true to their party lines on several issues under debate prior to the November election—and health care is no exception.

Ridge, the Republican candidate from Erie, is a veteran who is serving his fifth term in Congress. He has focused his campaign on bolstering business in the commonwealth and on making Pennsylvania "job friendly." His stance on health care reflects that focus.

"Pennsylvania is the solution in health care, not the problem, with some of the finest quality health care in the world," begins Ridge's one-pager on health care. "We have world class medical and research facilities, pioneering pharmaceutical and biotechnology companies, and hundreds of health care-related industries providing over 550,000 Pennsylvanians with good, steady jobs. In addition, more than 92 percent of our citizens already have some type of health coverage."

Ridge says we must "fix what is wrong with the system, while preserving what is right." He supports:

- making health care coverage universally accessible, portable, and more affordable;
- market-based reforms that provide consumer accountability and individual choice, while avoiding health care rationing, decreased innovation, and reduced quality;
- increased use of primary care;
- eliminating discrimination against individuals with pre-existing conditions; and
- administrative simplification that will reduce the vast amount of paperwork with which hospitals and health care providers now struggle.

Ridge adds that he opposes increased government bureaucracy and excessive government regulation, as well as mandates on employers to provide health care coverage to their employees. He concludes that the latter would destroy jobs, hurt small businesses, and harm the economy.

Singel's plan

Singel, the Democratic candidate originally from Johnstown, is serving his second term as lieutenant governor and is a former state senator. His "Ready Right Now" campaign focuses on the experience he gained during his six months as acting governor, while Governor Casey was on medical leave last year.

Singel supports the Pennsylvania Health Care Security Act, proposed by Governor Casey earlier this year. "The one principle that must be part of any health care reform is universal, guaranteed, private health care coverage," Singel says in a 12-page plan, "Guaranteeing Health Security," which he wrote at the beginning of his campaign.

But he also believes reform must go beyond universal coverage, and control health care costs and ensure access to care. He says that if elected governor, he would "implement the programs and initiatives needed to revive and rehabilitate Pennsylvania's health care system."

More specifically, Singel supports:

- a Health Insurance Bill of Rights that includes consumer safeguards—for example, ending denials because of pre-existing conditions and providing portability;
- a Managed Care Bill of Rights to preserve the right to receive medically necessary care from managed care organizations;
- mandatory arbitration of malpractice claims;
- banning self-referrals; and
- providing consumers with medical service cost and performance information.

He also would seek to promote appropriate and affordable long-term health care for older Pennsylvanians, guarantee access to primary care practitioners and services, and provide prenatal care to all pregnant women.

Editor's note: Due to the closeness of the election to this publication's press time, we chose only to review the platforms of the two major candidates.

SOCIETY OPINION PUBLISHED IN NEWSPAPERS STATEWIDE

The Society attracted media attention statewide as the result of an op-ed article by State Society President Martin A. Murcek, MD.

In the editorial, published by more than a dozen Pennsylvania newspapers, Dr. Murcek overviewed the Society's position on health system reform. "The Pennsylvania Medical Society believes strongly that any reform plan should result in all Americans having health care coverage," he wrote. "We want to guarantee that the quality of care under any reform plan will be at least as high as it is today. And we believe that the medical profession, not the government, is best suited to protecting and improving quality."

Also, he stressed the need for patients' freedom of choice, insurance reforms, administrative relief, professional liability reform, and antitrust relief in any health system reform legislation.

Dr. Murcek concluded, "Each physician has his or her own viewpoints about reform. But I speak with confidence when I say the greatest concern of each and every physician is that whatever reform plan is adopted, that our patients come out ahead of where they are now...And for heaven's sake, let's not fix what isn't broken."

State Society President Martin A. Murcek, MD, testifed at a public hearing, held this summer in Pittsburgh, on the "any willing provider" issue. He urged the legislature to resolve "this very controversial issue."

REFORM Progress Report

Volume II

An Update on:
Health System Reform (26B) • Marketplace (26C) • New Society Subsidiary (26E) • Hospital Mergers (26F) • Capitation (26H)

A Message from the President Elect

Dr. Hobart

Dear Colleagues:

Thanks—and I use that word advisedly—to some of our politicians, physicians have been portrayed as "Johnnies-come-lately" in the public discussion on health system reform.

To counter that portrayal, a PENNSYLVANIA MEDICINE article written 10 years ago, in June 1984, was recently called to my attention.

At that time, a young(er) urologist was quoted as saying: "The health care delivery system in our country is under more severe stress than it has ever been," and that addressing problems without addressing causes "is a little like trying to bail out a leaky boat without doing anything about the damn holes in the bottom."

I might not say it exactly the same way today—and probably not as temperately. But I agree with that younger, and perhaps less seasoned version of myself, that "the more input physicians can have in some of the things that take place, the better off everyone will be."

One might be somewhat despondent, realizing that we have been singing pretty much the same tune for at least 10 years—and that we've been right on key. I don't know whether that's been good or bad. The health system does need to change, but with physicians taking a leading role in that change.

Like Winston Churchill, we physicians never give in to the forces that threaten at times to overwhelm us. I am happy to be able to report that real change is taking place—not in the political arena, where many expected it, but in the health care marketplace.

I think you will read with interest the articles in this "Progress Report," as they deal with the issues of managed care, capitation, and the activities of our own PennMed Member Services Company.

As your incoming president, I am dedicated to strengthening the role of physicians in the health care delivery system. I want to help give our younger physicians some certainty about their future—a place where they can build their professional and personal lives. I will do all I can. But to succeed, we need the commitment and the support of the newest members of our profession. The importance of their involvement cannot be overestimated.

There are no simple answers. There are sophisticated, complicated solutions that must be hard won. And we're going to give it our best.

John H. Hobart, MD
President Elect, Pennsylvania Medical Society

Editor's Note: Dr. Hobart will assume office as president on October 22, 1994, during the Society's House of Delegates meeting.

As New Reform Plans Wither, Marketplace Matures

Roger F. Mecum

Executive Vice President, Pennsylvania Medical Society

Last November in this publication, we laid before you the AMA's and your State Society's coordinated efforts to place physician interests close to the heart of the newborn Clinton health system reform plan. We outlined Society activities around the state—hearing testimonies, coalition building, policy development—to reach the decision makers evaluating Governor Casey's new reform legislation. At the same time, we informed our members that we were devoting a substantial portion of our resources to developing products and services to help them deal with rapid marketplace changes occurring in tandem with legislative reform.

Since last fall, we have witnessed incredible, unpredictable changes occurring within and around both the federal and state health reform plans. But while chances for major legislative change have dwindled, change in the health care marketplace may have far exceeded anyone's predictions.

Recognizing this shift, this fall's "Progress Report" offers not only a capsule report of your State Society's activities in the legislative arena, but also recaps of the status of managed care, hospital mergers, physician integration, and the State Society's new initiatives to help you deal with these marketplace factors.

National reform withers

At press time, Congress had recessed following passage of the Crime Bill, with no major action on health system reform legislation. The four to six weeks remaining—between the return from Labor Day recess and House adjournment—seems a very short period in which to pass this massive legislation in both bodies. Many experts are saying that only incremental reform is politically viable in the short term; most efforts seem to point to insurance reforms as the first incremental step.

A Leader in the Debate

Over the past year, the State Society has exhibited tremendous leadership in the debate over health system reform. The Society's policy statements and legislative initiatives have clearly demonstrated our leadership role in the discussion on the Hill, as well as with business and community organizations and other health care professional associations.

The Society's credibility on the Hill has never been greater. We have appeared and offered advice at every opportunity in and out of government on this priority issue.

The Society will continue to strengthen our efforts as issues surrounding health system reform emerge, but the future will require a new intensity and new forms of advocacy that will be both challenging and exciting.

In addition to our recognized presence and expertise in legislative arenas, the State Society during the past year has provided an array of materials for members and their patients, to aid in understanding and communication of the issues. These efforts have included:

- Mailing educational materials to thousands of members: "talking point cards" on the major points; audio tapes describing the "The Storm of Reform" and outlining its affects on medical practice; position papers on managed care, liability reform, and other major reform issues.
- Providing speaker training sessions for member across the state.
- Publishing articles in our monthly publications updating members on every legislative initiative;
- Publishing our opinions on reform in hundreds of newspapers statewide as "letters to the editor" from State Society President Martin A. Murcek, MD.
- Performing numerous media interviews by Society leaders on many different facets of reform.

Health system reform is occurring rapidly in the marketplace regardless of the efforts of legislators to reform the system. *The Wall Street Journal* noted on August 26, "Health reform, which a year ago appeared certain to be shaped by a single, sweeping piece of legislation, now is likely to be forged in a marketplace tussle between cost-minded purchasers and rapidly merging providers…The latest setback for broad health care legislation reflects an inability to muster a legislative majority for any single approach…Even without a major bill this year, the U.S. health system will see extensive change."

During the Labor Day recess, the AMA and the Society urged members to meet or call their legislators regarding a number of reform provisions:

- oppose the "king of the hill" rule for consideration of health system reform, which unfairly stacks the deck in favor of the Democratic leadership;
- support the Rowland House Bipartisan Healthcare Reform Act;
- oppose the Gephardt House leadership bill, which includes a massive new federal program known as Medicare Part C.

On August 29, the Society agreed to participate in a coalition letter to U.S. senators reiterating support for Senate Bill 2196—the Patient Protection Act. State medical societies were asked to join more than 60 patient advocacy groups strongly urging support of this bill.

This was the culmination of a yearlong, hotly debated but furiousl paced, Federation campaign— perhaps medicine's most intensive effort since the passage of Medicare. The campaign has included advertising in

major newspapers and magazines nationwide; AMA leaders testifying before the Senate Labor Committee on antitrust reform and other influential committees on reform related issues; press conferences in Washington, DC, to announce Federation positions, reactions, and plans; and massive grassroots efforts to encourage physicians to communicate with Congress as pressure points were reached in the health system reform debate throughout the year.

An AMA survey in mid-year showed that the public believes physicians are the most important source of information on health system reform.

Your State Society has closely monitored this campaign on a daily and sometimes hourly basis throughout the past year. Through our computer link with the AMA, and other technologies such as teleconferencing, we have been an active participant in Federation planning and communications.

Statewide reform languishes

With Governor Casey's illness, changes in legislative balance and leadership, and the diminishing of hope for national legislation, Pennsylvania's chances for major health system reform also dwindled over the summer.

Many key legislators, including House Majority Leader Ivan Itkin (D-Allegheny), have stated that Pennsylvania would only act on health system reform after the U.S. Congress addressed the issue. To the extent that Washington does not address the issue, we expect that pressure will build for Pennsylvania to act. For this reason, your Society continues constant monitoring and participation in all areas of state reform discussions.

Over the summer months, Senator Arlen Specter hosted a series of "forums" on health system reform. Your State Society attended. As State Senator Raphael Mustow (D-Luzerne) and others continued to push an "any willing provider bill," the State Society entered the debate. Society President Martin A. Murcek, MD, testified at a joint hearing of the House Insurance Committee and the Senate Public Health and Welfare Committee in August in Pittsburgh. "At the heart of this issue is the question of the fundamental right of patients to have a voice in choosing who keeps them well and who treats their illnesses," he said.

The Society's view on this and other issues was broadcast widely through "op-ed" articles in newspapers throughout the state.

One of the most significant developments of the summer has been the work of Senator John Peterson's (D-Chester) office to draft an insurance reform bill for consideration in the Pennsylvania General Assembly. The Society has worked with the Senate Health and Welfare Committee, chaired by Senator Peterson, to achieve changes in the language consistent with Society policy.

Progress Report

Race Toward Managed Care Accelerates

Roger F. Mecum

Executive Vice President, Pennsylvania Medical Society

Throughout the past year, health care marketplace activity has continued to accelerate toward managed care. The Group Health Association now estimates that over 18 percent of the Pennsylvania market is insured by health maintenance organizations (HMOs), higher now than the national average. Over the next two years, the move toward full capitation is expected to jump 20 percent nationwide. In rural areas, managed care is expected to increase four-fold, and Medicare is seeking to reduce inpatient utilization in Pennsylvania by more than 25 percent.

This past August, a large multi-specialty group practice in suburban Pittsburgh was purchased by Blue Cross of Western Pennsylvania, the first of several such acquisitions to be announced this fall. Blue Cross plans across the state are talking with physi-

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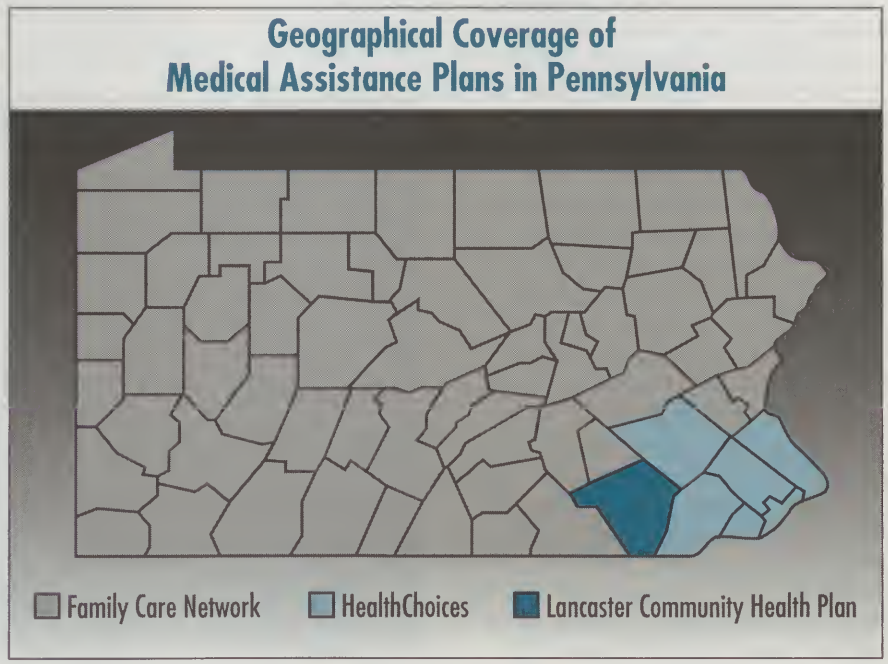

cian groups to explore future joint or purchase arrangements.

But the Blues are not the only insurers talking to physician groups. U.S. Healthcare is expanding activities in central Pennsylvania, and HealthAmerica is developing in the Pittsburgh and Harrisburg regions, and intends to expand to other areas of the state, excluding Philadelphia. Pennsylvania Blue Shield's new network, PremierBlue, has been growing, despite complaints from the physician community concerning its exclusionary practices.

Meanwhile, the Society is continuing to conduct a series of meetings throughout the state to encourage physicians to form physician organizations (POs) and independent practice organizations (IPAs) to position physicians to negotiate effectively within these marketplace movements.

The Society's efforts to assist physicians in these areas is also meeting challenges. Blue Cross of Western Pennsylvania, which holds 65 percent of the health insurance market in the Pittsburgh region, is negotiating with physicians to create a management services organization (MSO) to provide administrative and practice management services to physicians. This type of activity is in direct competition with the efforts of the Society through its newly created subsidiary, PennMed Member Services Company (PMSCO), to offer similar services to physician groups (see "PMSCO" sidebar, next page).

MA restructuring

We reported in June that the Department of Public Welfare (DPW) plan to launch three new programs for providing medical services to Pennsylvania's Medical Assistance (MA) patients was proceeding on schedule. All three programs—each serving a different geographical area—will require MA recipients to choose a single provider for primary care, but they differ in significant ways.

The largest of the three in geographical coverage is the Family Care Network, which will serve children and youth under 21 years of age in 60 counties of the state on a fee-for-service basis. Almost as large in terms of eligible clients, HealthChoices will offer a choice among managed care plans to individuals of all ages within Philadelphia County and five adjacent counties—Berks, Bucks, Chester, Delaware, and Montgomery—which together contain roughly 40 percent of the state's MA recipients. The smallest, but potentially most ambitious program, is the Lancaster Community Health Plan. Limited to Lancaster County, it will begin as a fee-for-service program for patients of all ages, and is later slated to include a comprehensive computer database and a managed care option.

Family Care Network

The Medical Assistance primary care case management initiative to provide care to those under age 21 in 60 counties is being well received by most of the provider community. The department is already in phase four of provider recruitment. A state map on page 26C indicates the phases as they are currently being implemented.

Problems have arisen in some of the smaller counties, but generally the department is receiving physician commitments for patient caseloads at twice to three times the number of eligible MA recipients in the county being recruited.

Philadelphia-area proposals

DPW is now in the final stages of review of 12 proposals submitted in response to the request for proposal to expand HealthChoices, the managed care health insurance organization (HIO) in the six southeastern counties surrounding the city of Philadelphia. Many of the proposals bid on all three of the geographic areas created arbitrarily to equalize Medical Assistance populations in the areas. It was anticipated that Welfare Secretary Karen Snider would announce the successful bidders sometime after Labor Day. At press time, that announcement had not yet been made.

Also this fall, the suit brought on behalf of welfare rights groups and the Hospital Association of Pennsylvania to block the awarding of the HIO contracts was expected to be resolved. The judge who heard the original case seeking the injunction against the department is retiring. At press time, both sides have been attempting to negotiate a settlement.

Lancaster Community Health Plan

The contract between the DPW and the Lancaster Community Health Plan (LCHP) to implement a primary care case management plan for the MA population of Lancaster County is proceeding through the department's approval process and is expected to be finalized in mid-September.

LCHP, with the assistance of KPMG Peat Marwick, is currently putting the staffing and work plan in place to be ready to begin provider recruitment and patient enrollment later this fall. Work is also proceeding on the computerized community patient information network (CPIN), which will be unique to the LCHP project.

"Meanwhile, the Society is continuing to conduct a series of meetings throughout the state to encourage physicians to form physician organizations (POs) and independent practice organizations (IPAs) to position physicians to negotiate effectively within these marketplace movements."

New Subsidiary Helps Physicians Unite

Judd Mellinger-Blouch

Acting Marketing Manager, PennMed Member Services Company (PMSCO)

As managed care reaches into every corner of the commonwealth, the Pennsylvania Medical Society is actively working to give its members the skills and knowledge necessary to deal with these radical reforms. This work has taken place on two fronts: outreach through a new for-profit subsidiary and within the State Society itself.

Unite and lead

Only a year ago, an idea was approved by the Society's House of Delegates; within little more than six months, a new company was formed by the PennMed Board of Directors. The idea was to provide a service through the State Society which could help physicians evaluate the best possible practice arrangements—whether small practices or large, comprehensive plans or single problems.

Now, in October 1994, PennMed Member Services Company, better know as "PMSCO" (pronounced "pim-sco"), is leading the effort to help Pennsylvania physicians maintain a leadership role in the ever-changing health care system.

"If physicians want to have a voice in the reforms coming our way, then they need to unite and work together," according to Michael J. Prendergast, MD, chair of the PMSCO Board of Directors.

PMSCO's first order of business has been getting physicians to work together. While many physicians are accustomed to and prefer working solo or in a small group practice, they also understand that organizing into larger entities, such as individual practice associations (IPAs) or "group without walls," is becoming a necessity.

PMSCO has already signed contracts and begun working with a number of physicians around the state. Meanwhile, PMSCO staff continue to crisscross the commonwealth, making presentations on forming physician organizations (POs), meeting with concerned physicians, and submitting proposals.

Recently, a PMSCO presentation in a medium-sized city resulted in a contract to investigate the feasibility of such a physician organization. According to one of the leaders of the organizing effort, there were two reasons why a PO was needed: "The local hospital was seriously considering the start-up of a physician hospital organization (PHO), and we knew that if we were going to get involved in a PHO, it would be in the physicians' best interests to organize. The hospital also decided to start a medical group by buying up practices and putting people on salary. This caused a lot of concern among independent physicians."

First, PMSCO looked at the health care market by interviewing employers, purchasers, and providers, and reviewing health care provider data and demographics. A report at the end of the first phase of this effort told the physicians that the market could support the formation of a PO. The second phase involved the actual creation of the PO model that will best meet the needs of the market and the physicians involved.

One of the organizing physicians now reports, "Our long-term goal is to start a PO which would be structured to allow us to deal with risk taking, capitation, and the initiatives by our local hospital."

Information management is also a high priority for PMSCO. Various utilization management and quality assurance products and models are being analyzed. PMSCO staff is talking to practice managers, third-party payers, and others to hear about their information management concerns. The goal is to become a central resource to which PMSCO clients can turn when they need assistance handling the rapidly growing and changing demands for cost and quality data.

Managed care resources

While PMSCO works directly with individual physicians and groups, the State Society aims its broader efforts at providing information and resources on managed care to members. Through special publications and cutting-edge seminars, the Society has worked intensely over the past year to provide physicians the information they need to survive and thrive in a managed care environment.

This fall, the Society will offer the third installment in a series of managed care seminars. They are:

- "Successful Integration (How Physicians Can Work Together)" and "Health Care Contracting in an Era of Reform," to be held October 12 in State College and October 13 in Wilkes Barre.
- "Managing Information in a Managed Care Environment" and Making Capitation Work for You," to be held November 16 in Pittsburgh, and November 17 in Philadelphia.

Other seminars offer training in managing a medical practice and maximizing income despite the constricts of managed care and government regulation. For more information, call Linda Boyer at (800) 228-7823.

Other resources available from the State Society include the Managed Care Resource Kit and the Managed Care Handbook. The Resource Kit, free to Society members, includes listings of pertinent journals and publications, selected managed care articles, listings of PPOs and HMOs, Society position papers, the Society's Practice Management Consulting Network, and more. The Managed Care Handbook, prepared by Conomikes Associates, provides more detailed planning information for physician practices facing decisions regarding managed care in their local marketplace.

For a complete list of State Society publications or seminars, or to order one of these publications, call the Department of Physicians Services at (800) 228-7823.

For more information about PMSCO and physician integration and organization, call Sharon Orlowski or Cathy Williams at (800) 228-7823.

Health Care Providers Propelled Toward Mergers

Fred D. Baldwin

PENNSYLVANIA MEDICINE contributing author

Like commuters scrambling for a train they fear may be leaving the station, Pennsylvania hospitals have been scrambling this year to form agreements intended to protect or expand their market niches.

The agreements range in form from general cooperative agreements to full-fledged mergers, and they may link hospitals to each other or to insurance companies.

"A major driving force is the prospect of health care reform," says Lou Gable, director of media relations, Hospital Association of Pennsylvania. "Nobody is sure what it's going to look like. But no matter whose bill passes, or even if no legislation is enacted, market forces are reshaping health care. The trend is toward managed care. And when you get to managed care, you have to be large to compete, or find a niche."

Both participants and outside analysts agree that market forces are more important than politics. Improvements in medical technology and medical procedures have affected hospital economics on both the cost and revenue sides of their ledgers.

On the cost side, referring to what some call the "arms race in medicine," Gable notes that "competition in the medical field tends to increase costs, not lower them. If the hospital down the road has MRI, you have to have it or lose your patients."

At the same time, improved technology and procedures have shortened hospital stays, so that, on average, hospital occupancy rates are below 70 percent.

"Demand for hospital care in general has dropped fairly dramatically," says Mark Pauly, chair of the Department of Healthcare Studies at the University of Pennsylvania's Wharton School of Business. "Rather than having a hospital go bankrupt, a more graceful way out is to merge with the hospital down the street."

"Continued cutbacks in Medicare payments are another worry," says Gable. "Hospital CEOs are looking at what's being proposed in Washington and thinking, 'Oh, my Lord!' "

Another factor driving hospital agreements is the increased bargaining power of health maintenance organizations (HMOs). Pauly calls mergers and other agreements a "circle-the-wagons" response to managed care.

> ***"Nobody is sure what it's going to look like. But no matter whose bill passes, or even if no legislation is enacted, market forces are reshaping health care."***
>
> ***—Lou Gable***
> ***Hospital Association of Pennsylvania***

Although the *Philadelphia Inquirer* recently described hospitals as in the grip of "merger mania," there appears to be no one source of statewide statistics on the trend. The problem for record-keepers is that agreements that do not involve changes in ownership structure often need not be reported to state agencies—but such agreements are not necessarily exempt from antitrust scrutiny by the attorney general. (See box on the next page for the perspective from the Attorney General's Office.)

In general, hospitals may form alliances for any or all of three reasons:

1) They may wish to improve their negotiating positions, especially with insurance companies and HMOs. This consideration has been mentioned in reports on plans to create regional networks of hospitals in Harrisburg, Lancaster, Reading, and York areas.

2) They hope to reduce administrative overhead. A merger of three Lycoming County hospitals has been projected to save $40 million over five years, but the attorney general's office has insisted that over three-quarters of this be returned to consumers in the form of lower costs. Proponents of a planned merger between Geisinger Medical Center and Bloomsburg Hospital have expressed hopes that the planned merger could save between $1.5 and $2 million annually.

Although virtually all announcements of new alliances mention cost savings as an expected benefit, Pauly doubts that these savings will materialize to the extent expected. "The general message of the research," he says, "seems to be that bigger hospitals aren't necessarily more efficient than smaller ones. All you get are some economies in the laundry room and in designing logos."

3) Profitable hospitals also merge to increase access to new market segments. Improved market positioning underlies an agreement between InterCare Behavioral Health Services of Pittsburgh and the Belmont Center for Comprehensive Treatment (in Philadelphia and itself one of four hospitals in the 1,000-bed Albert Einstein HealthCare Network) to form a preferred provider organization (PPO). PPO providers generally accept discounted fees for improved access to certain groups of patients. InterCare and Belmont hope to be able to offer almost statewide managed care services to mental health patients.

According to an article in the May/June 1994 *Group Practice Journal,* collaborative agreements among health care institutions often

go through successive stages, although there is nothing inevitable about the progression. The first stage consists of simple agreements to cooperate in matters like patient referrals. The second stage involves administrative mergers. The third involves establishment of common clinical standards. The fourth stage consists of a total financial merger.

Gable says that most concerns over proposed mergers arise from community groups fearful that they'll lose easy access to service: "They say, 'You're not going to take away *my* hospital!' " He notes that such fears produced a major public outcry protesting a merger between hospitals in Oil City and Franklin, both located in sparsely populated Venango County, roughly halfway between Pittsburgh and Erie.

The following list of agreements is compiled from press reports and is not necessarily complete. It does suggest the extent to which the institutional face of health care in Pennsylvania is changing.

- Hahnemann University announced in April that it would merge all of its operations into a new $1.5 billion organization headquartered in Pittsburgh. It thus became part of the Allegheny Health, Education and Research Foundation, a 2,000-bed hospital and research network already consisting of four Philadelphia-area hospitals and the Medical College of Pennsylvania.The merger of Hahnemann and the Medical College of Pennsylvania will make the new institution the second largest in the nation.
- In June, Presbyterian Medical Center of Philadelphia said it would join a new medical network set up by Independence Blue Cross. Independence Blue Cross itself announced a merger with Graduate Health System to create one of the region's largest private companies with combined revenues of $2.5 billion.
- Thomas Jefferson University joined with Pennsylvania Hospital, and Northeastern Health System formed an alliance with Temple University Hospital.
- The University of Pennsylvania Health System (UPHS) and Germantown Hospital and Medical Center signed a formal affiliation agreement in April. This became the first step toward creating a UPHS network of community hospitals linked with physician groups and other providers throughout the Greater Delaware Valley.
- Five other Philadelphia-area community hospitals have begun negotiations to form a combination large enough to compete effectively. The five are Chestnut Hill Hospital (Philadelphia), Pottstown Memorial Medical Center, Montgomery Hospital (Norristown), Grand View Hospital (Sellersville), and Chester County Hospital (West Chester).

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Antitrust Law and Mergers: The Attorney General's Review

"There's this sea of change underway," says Robert R. Gentzel, spokes person for the Pennsylvania Attorney General, Ernie Preate, Jr. "It's gone from an area where we didn't have any issues to one where there are significant issues—among them, physician access."

Gentzel is referring to the wave of mergers and other alliances among hospitals and other provider entities. He notes that agreements less formal than full mergers (for example, to divide medical specialties between hospitals) may hurt both physicians and consumers and be considered "restraints on trade." Yet he emphasizes that a review of proposed merger for antitrust implications does not necessarily lead to either state or federal intervention.

In one recent instance, however, Preate permitted a merger of three Williamsport-area hospitals to go forward uncontested only when the hospitals involved agreed to pass on $31.5 million of a projected $40 million cost savings (over a five-year period) to area residents in the form of free or reduced-cost health care. Other provisions of the May 1994 agreement forbade the newly created Susquehanna Regional Healthcare Alliance from entering into exclusive contracts with most classes of health care providers (excluding emergency room physicians, anesthesiologists, radiologists, and certain other specialists who often work as employees). The alliance must also provide an open staff and may not, with a few defined exceptions, employ more than 40 percent of the physicians in Lycoming County.

Antitrust laws are based on the premise that vigorous competition ensures that consumers will receive the highest quality products at the lowest prices. These laws generally prohibit mergers that will result in large concentrations of market power that would give the merger entity the power to reduce output or raise prices above levels that would exist under conditions of open competition.

Daniel Clearfield, Pennsylvania's deputy attorney general in charge of the Public Protection Division, explains that his office uses an econometric model that measures market concentration endorsed by the U.S. Justice Department and Federal Trade Commission to assess whether a proposed merger is likely to have an unduly adverse effect on competition. The model is complex, but the AG tends to become concerned when any vendor captures more than 40 percent of the market within the geographical area within which it competes.

Clearfield cautions that this rule of thumb can be hard to apply to hospital mergers, especially in rural areas. In regions already served by only a few hospitals, almost any consolidation is likely to set off warning bells. However, unprofitable hospitals may rely on a "failing company" defense, or the AG may also approve anti-competitive mergers among profitable hospitals if it can be shown that an alliance will produce consumer savings.

"In Williamsport," he says, "concentration levels were very high after the merger. But the benefits were so high that they offset them."

Several bills have recently been introduced in Congress to exempt certain health care mergers from federal or state antitrust scrutiny. Clearfield says that he has not analyzed those bills closely, but that they generally seek to make it easier for a hospital to employ the "failing company" defense.

Taken together, they have approximately 1,300 beds. As of late July, a spokesperson described these institutions' talks as "preliminary," indicating that they could lead to anything from a full merger to some other kind of joint venture.

- Mercy Health Plans and Aetna Health Plans announced in August a partnership to link services in Luzerne, Lackawanna, Carbon, and Wayne counties to the Lehigh Valley, Central Pennsylvania, and the five-county Philadelphia area. This arrangement makes Aetna the largest HMO in Pennsylvania, managing health care for more than 400,000 Pennsylvania residents.
- Geisinger Medical Center and the Bloomsburg Hospital announced intentions to merge and began public forums to discuss the idea.
- Pittsburgh's Divine Providence Hospital, the smallest in that city, announced in March that it would become part of Mercy Health system, the nation's second largest system of hospitals.
- Capital Health System (Harrisburg Hospital) and Polyclinic Medical Center, also in Harrisburg, announced in July a formal plan to merge operations. Capital Health System is also reported as considering formation of a regional network with Lancaster General Hospital, York Hospital, and the Reading Hospital and Medical Center.
- Also in the Harrisburg area, Penn State's Milton S. Hershey Medical Center and Holy Spirit Hospital, Camp Hill, have announced a formal agreement to affiliate. Hershey is already affiliated with St. Vincent Hospital in Erie and Lehigh Valley Hospital, and has had "very preliminary" talks about an affiliation with St. Joseph Hospital. The Carlisle General Hospital is also reported as considering a Hershey-Holy Spirit alliance.
- In Williamsport, three of Lycoming County's four hospitals—Williamsport Hospital and Medical Center, Divine Providence Hospital, and Muncy Valley Hospital (already a subsidiary of Divine Providence)—created a joint operation known as Susquehanna Regional Healthcare. This merger led to intervention by the Pennsylvania attorney general, resulting in a settlement by which over $30 million of a projected $40 million in cost savings would be applied to consumer benefits.
- Suburban General Hospital in Bellevue and the Western Pennsylvania Hospital in Bloomfield have agreed to discuss affiliation.

Progress Report

Capitation: The Upside Vs. the Downside

Cathy A. Williams

Practice Management Consultant, PennMed Member Services Company (PMSCO)

Portions of this article incorporate research materials prepared by the American Medical Association. The Society appreciates the use of the AMA materials.

Physicians have historically been reimbursed on a fee-for-service basis—whether paid for by farm produce, as recorded in some early county medical society publications, or by modern health care insurance plans. But, as physicians well know, many new and different reimbursement methods—most notably capitation—have surfaced in the '90s. The overriding goals of most of these methods is to control costs by shifting risk to providers.

In the near future almost every physician in the state will face a decision about capitation.

An overview

Capitated providers often are said to be "at risk" because they receive the same payment per enrollee regardless of their enrollees' actual utilization. Some contracts provide minimal copayments for certain services, such as visits. However, capitation payments are not increased when enrollees become seriously ill and require expensive care—nor reduced for enrollees who remain healthy and do not need much care. Capitated providers profit to the extent that their expenses are below their capitation payments, and they incur a loss if their expenses exceed those payments.

Under pure fee-for-service payment arrangements, providers risk that their cost of delivering a service will be above the payment allowance for the service, but the payer alone assumes the risk that enrollees will have higher-than-projected utilization. Capitation shifts the utilization risk to the provider. If the utilization of enrollees assigned to a capitated provider is higher than anticipated by the capitation rate, the provider's profit margin will decline, and the provider may even incur a loss.

Capitation is an opportunity to maximize revenues. It challenges providers to efficiently manage their enrollees' utilization, so that their delivery costs are below their aggregate capitation payments.

But capitation also makes providers liable for any resulting losses when factors outside of their control result in high utilization, despite their best efforts at efficient clinical management. These uncontrollable factors include patient demand, other provider referrals, errant actuarial assumptions, or adverse selection. (Adverse selection occurs when the patients assigned to a physician need more care than the enrollee population as a whole.)

Capitation necessitates limitations on enrollee freedom of choice of provider. As a practical matter, enrollees must be required to select, or be assigned to, a specific provider for capitated services. Otherwise, the payer could end up routinely paying twice for capitated services: once through a capitation payment to a provider, and then again when the enrollee uses a different provider. As a result, capitation typically is only used by health

maintenance organizations (HMOs) and independent practice organizations that subcontract with an HMO on a global capitation basis.

Other managed care payers, such as preferred provider organizations (PPOs) generally do not require enrollees to use a specific provider. However, the lines between the various types of managed care plans are blurring. For example, some PPO plans "carve out" a category of services and require enrollees to use a single provider—called a "center of excellence"—or a select network for the carved-out services. In those cases, the PPO might elect to pay the designated providers on a capitation basis. Capitation carve-outs are becoming more common, especially in the case of mental health and psychiatric services.

Will the HMO Negotiate?

It depends upon how much the HMO needs you. Generally speaking, when an HMO first enters a market, the HMO is more accommodating to physicians and more willing to bargain over price and other terms of capitation arrangement. The HMO needs broad-based physician participation so that it can, in turn, convincingly demonstrate to prospective groups and individual enrollees that they will have the same—if not better—access to a wide selection of quality providers, and may not even have to change their personal physicians.

On the other hand, once an HMO is established in a market area, and has both a comfortable enrollee base and a complete provider panel, the HMO may be less inclined to negotiate with providers. Some HMOs essentially adopt a take-it-or-leave-it attitude, especially with respect to provders in over-supply in the area. If an HMO only needs 10 cardiologists to take care of its enrollee population, and there are 20 in the area, the HMO may be willing to take the risk that half will be willing to accept its unilateral terms.

Physicians also are handicapped by the antitrust laws. Physicians cannot band together and collectively bargain with an HMO. The antitrust authorities view such conduct as price fixing and/or a group boycott—both per se violations of the antitrust laws and punishable by severe criminal and civil penalties. The AMA is working hard to convince Congress to reform the antitrust laws to level the playing field. However, for the present, individual physician-HMO negotiations are often akin to David against Goliath.

On the brighter side, not all HMOs are interested in price alone. Physicians also frequently can take steps to better equip themselves to compete in the managed care market. One option physicians should consider is the formation of a physician-led integrated delivery system (IDS), such as an independent practice association (IPA) or a large multi-specialty group practice that owns or is aligned with a hospital system. If these IDSs are economically integrated and provide a new product, they can anticipate a measure of antitrust protection.

The upside of capitation

Capitation can benefit payers, physicians, and their patients when safeguards are in place to protect quality and access.

The most commonly cited benefit of capitation is that it provides an added incentive for physicians to maintain their patients in good health and to craft a cost-efficient treatment plan when their patients need care.

A less talked about, but equally positive benefit of capitation is that it puts physicians back in charge of the medical management of their patients. The goal is quality care at reduced cost.

Most physicians paid on a fee-for-service basis deliver cost-efficient care. However, capitation and other risk-assuming payment mechanisms create an added incentive for physicians to efficiently manage their patients' care. Putting physicians in a position to profit or incur a loss—depending upon the cost-effectiveness of their clinical management—makes them stakeholders and even more inclined to practice cost-efficient medicine (as well as provide superior quality care). Returning the medical management to practicing physicians also makes since they are in the best position—other than patients themselves—to influence utilization.

When physicians are at risk for the services they manage, there is potential for cost savings. While physician payments account for only about 20 percent of the health care dollar, physician practice patterns and prescribing have been estimated to account for 60 to 80 percent of all health care expenditures.

For example, a hospital can reduce its cost of operation through more efficient management and purchasing of supplies and services. However, only physicians can control inpatient admissions and lengths of stays—and only physicians can control the services ordered during the patient's admission.

"Capitation can benefit payers, physicians, and their patients when safeguards are in place to protect quality and access."

Risk-assuming, physician-led integrated delivery systems—armed with a sophisticated clinical management system—can be extremely effective in implementing innovative cost saving and quality improvement strategies. The physicians work together to address the entire continuum of care, rather than isolated events or the care of a single provider—and possess the ideal combination of motivation, expertise, and professionalism. Indeed, experience shows that putting physician-led systems at risk can be more effective in limiting costs, and less expensive to administer, than payer-driven utilization review and cost control efforts.

The Permanente Medical Group, associated with the Kaiser HMOs in California, is an example of a physician-led integrated delivery system that has found creative ways to reduce costs without compromising quality. The group engages in intensive preventive care, including the management of patients with chronic illnesses such as asthma, to minimize the number of occasions acute care

intervention is needed. The patient remains in better health, and costs are reduced by decreasing hospitalizations. These kinds of medical management techniques have allowed physician-led systems across the country to be successful.

Physician-led systems also can provide tough competition in an HMO market that is becoming increasingly dominated by a few large insurers. For example, in the Los Angeles market where a majority of the population is enrolled in HMOs, a physician-led health plan offered by the Mullikin Medical Centers recently offered the lowest premiums. In Boston, a physician-led HMO offers the lowest prices.

These physician-led systems have the capacity to eliminate waste and lower cost because they do not have the administrative overhead and profit margins of insurance companies and are better equipped to manage care efficiently.

Don't Forget Your Professional Liability Exposure!

Managed care, by itself, does not expose a physician to professional liability risk. Indeed, a physician-led IDS may be able to reduce malpractice risk by improving the quality of care. However, physicians subject themselves to professional liability risk if they allow the requirements and incentives of a managed care plan to compromise the quality of care they provide. Neither a physician's contractual obligations, nor the physician's monetary woes, will be a valid defense in a professional liability action. Remember:

- If the plan limits the number of referrals to out-of-network providers, make sure that the provider network contains an adequate number and distribution of high caliber providers, that primary care physicians have access to a sufficient number of specialists, and that exceptions are allowed in emergencies and when the enrollee needs specialized care not available through the network.
- If you disagree with a pre-authorization denial, appeal the denial to the highest level and be honest with your patient regarding your recommended treatment plan.
- Never refuse medically appropriate care for financial considerations. Treat your managed care patient with the same professionalism as you care for your fee-for-service patients.
- Don't agree to provide services that you are incapable of delivering consistent with the standard of care—unless you can subcontract that work to another qualified provider.

Profit sharing, autonomy, quality

Capitation allows physicians to share in the profits of their effective clinical management. A globally capitated integrated delivery system can use those profits to increase provider reimbursement or re-invest them in the delivery system to improve efficiency and quality.

In contrast, under a fee-for-service system, the profits from sound physician clinical decision making largely go to the payer and may be siphoned out of the system to the payer's investors. While the managed care payer may have a bonus system in place, distribution of the fund frequently is discretionary, and the total distributions typically are relatively small when compared with the payer's profits.

Capitation also puts physicians back in charge of clinical management. Providers and their patients like the resulting autonomy. When a service is covered by a capitation payment, the capitated provider or integrated delivery system makes the decision as to whether the care is provided.

Physicians are sometimes intimidated by capitation, at least initially. It is a radical departure from what they are accustomed to. They are concerned that "free" care will result in increased patient demands, and they are not comforted by HMO claims of minimal risk. However, as physicians gain experience with capitation, many realize that they can profit from a fair capitation arrangement, and like the autonomy and guaranteed income. Physicians also do not like to see the profits from their sound clinical management siphoned out of the health care system to a managed care payer's investors, and are increasingly opting for capitation and other risk-shifting arrangements that retain the profits within the health care system.

The downside of capitation

From the provider perspective, an obvious downside of capitation is the risk of loss. Capitated providers will lose money if their cost of delivering the care is greater than their aggregate capitation payments, any copayments they are due and able to collect, plus any stop-loss or reinsurance revenue. As in the case of any reimbursement mechanism, providers may lose money if they under estimate their per-unit costs. However, capitated providers can also lose money if their enrollees' utilization is higher than the capitation rate can absorb.

"Physicians are sometimes intimidated by capitation, at least initially."

In contrast to pure fee-for-service, capitated physicians who fail to efficiently manage the delivery of capitated services to their enrollees may incur losses. When managed care payers project utilization for purposes of determining the capitation rate, they expect utilization lower than would be expected under a fee-for-service system—not "business as usual." Some physicians will need to adapt their clinical management styles in order to succeed under a capitated system.

Of concern are factors beyond the physician's control which may put the physician in the red at the end of the month:

- Difficulty in predicting utilization, especially on a specialty-specific level. An actuary could correctly project overall physician utiliza-

tion, but miss the mark when allocating physician expenses among the various specialties.

- The capitated physician alone does not control utilization. Patient demand and provider referrals also strongly impact utilization, especially in the case of initial visits.
- A capitated physician also could be the victim of adverse selection. For example, the enrollees who select a primary care physician as their gatekeeper may be sicker and need considerably more visits, laboratory work, and other capitated services than the HMO's enrollees as a whole.

In light of these risks, it is obvious that tomorrow's successful physician will be the one who minimizes the threats and maximizes the many opportunities of a captiated payment system. Such a physician will have the skills to analyze the risk potential posed by a group of capitated patients, negotiate an appropriate contract with the payer, and then provide quality patient care for a cost that is below the capitation rate.

PMSCO and the Pennsylvania Medical Society will continue their efforts to help physicians deal with capitation, both economically and clinically. Any physicians with questions or concerns should call PMSCO or the Society's Department of Medical Economics at (800) 228-7823.

IDS Clinical Management Systems

A sophisticated clinical management system provides the integrated delivery system (IDS) with all the tools needed to measure, evaluate, and improve the quality and cost effectiveness of care, including:

- Utilization review (UR)
- Quality assurance (QA)
- Resource utilization management (RUM)
- Outcomes measurement
- Clinical guidelines, and
- Risk management

Advantages of Physician Integration

- *Better "value"*—Physician-led integrated delivery systems (IDSs) often can deliver better value, i.e. maximizing quality and patient satisfaction, while minimizing cost, because of efficiencies and improvements resulting from sophisticated information systems, "seamless" care, economies of scale, group purchasing discounts, management expertise, etc.
- *Sophisticated information systems*—Shared financial and clinical data allow IDSs and their members to compare providers and review the complete picture, i.e., the entire episode of care versus individual units of care. This data can be used to improve practice and clinical management, and is essential for effective marketing.
- *"Seamless care"*—A fragmented delivery system can result in duplication of services and lack of coordination among providers, both of which can be reduced through integration. For example, IDSs can reduce the lengths of stay of patients waiting for nursing home beds by anticipating the needs of their patients and "purchasing" the beds in advance. Trust and communication among the IDS members also can reduce tests and procedures.
- *Economies of scale*—These can be obtained through broader distribution of fixed costs, increased productivity from increased volume, and reduced duplication of tasks, technology, and facilities. For example, physicians can reduce their fixed cost of operating a laboratory and their variable test processing cost by sharing a single high volume laboratory.
- *Group purchasing discounts*—These are often available for medical and office supplies, furnishings, equipment, and space; health care, life disability, professional liability, and other insurance; practice management and consultative services; billing and collection services, etc.
- *Administrative relief*—Pooling of resources and practice needs facilitates acquisition of practice management staff and expert legal and other consultation services that are not feasible or practical for physicians to individually obtain, and leaves physicians free to practice medicine.
- *Capacity*—Many HMOs and other managed care payers would prefer to deal with a single physician-led IDS that can deliver a broad package of medical services, and avoid the expense and hassle of dealing with a multitude of individual providers.
- *Global capitation*—Both physicians and their patients can realize advantages from global capitation and other risk-assuming payment mechanisms.
- *Access to capital*—Integration can increase access to capital needed to improve information systems, expand facilities, purchase new technology, and finance other projects undertaken to maintain and improve competitive viability.
- *Patient referrals/admissions*—Legally sound ways to direct the flow of patients are especially important in those areas where there is intensive competition for patients as a result of an excess supply of specialists or beds.
- *Reduced isolation*—"On call" and other coverage availability, as well as opportunities for consultation and increased interaction with other physicians, can improve with integration and make integration especially attractive to rural physicians.
- *Physician unity*—An IDS provides a framework for group decision making and communication with other players. For example, a physician organization can be especially helpful when dealing with a hospital regarding a physician/hospital joint venture by enabling physicians to speak with one voice.

The Society acknowledges that physician-led IDSs can be beneficial to physicians and their patients, and has formed a consulting company, PennMed Member Services Company (PMSCO), to assist physicians in taking a leadership role in the integration movement. At the same time, the Society recognizes that physicians can provide quality, cost-efficient care without being aligned with an IDS, and we support the right of physicians to freely choose the location and setting in which they deliver care and how they are aligned with other providers.

FAX REQUEST ORDER FORM

PENNSYLVANIA MEDICAL SOCIETY

FAX NUMBER: (717) 558-7840
PHONE NUMBER: (717) 558-7750

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☐ State Society Member ☐ Non-member

PLEASE SEND ME THE FOLLOWING FREE MATERIALS:

SOCIETY WHITE PAPERS:

☐ Health System Reform

☐ Managed Care

☐ Primary Care Physician Shortage

☐ Tort Reform

☐ Capitation (to be available soon)

SPEECHES FOR PHYSICIANS SPEAKING TO NON-PHYSICIAN AUDIENCES:

☐ Health System Reform

☐ Managed Care

PHYSICIAN INTEGRATION SERVICES

☐ Send me more information about PennMed Member Services Company (PMSCO).

☐ I am interested in the speakers available to address my group about PMSCO.

TALKING POINTS:

☐ A set of nine cards on the following topics:

Freedom of Choice
Quality Safeguards
Tort Reform
Local Solutions
Primary Care Physician Shortage
Preventive Care, Early Detection Healthy Living
The Physician's Role in Health System Reform
Governor Casey's Health Reform Package
President Clinton's Health Reform Package

PRODUCTS AND SERVICES:

☐ Managed Care Resource Kit

☐ Information on Managed Care Consulting Services

☐ Seminar Information on (topic) _____

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REPORT STUDIES STATE'S UNINSURED CHILDREN

An estimated 250,000 children in the commonwealth under the age of 18 are without health insurance, according to a special report released this summer by the Pennsylvania KIDS COUNT Partnership.

The report, "Uninsured Children in Pennsylvania," says the lack of insurance and inadequate resources are the major reasons why children and adolescents do not receive primary and preventive health care.

Other key findings include:

- Children under the age of 6 and children over the age of 14 are less likely to have health insurance than children ages 6-13.
- Children under the age of 6 account for 36.5 percent of all uninsured children.
- There are 112,501 children without health insurance whose annual family income is between $14,800 and $29,599; 24,242 children without health insurance whose annual family income is between $34,781 and $44,399; and 47,501 children without health insurance whose annual family income exceeds $44,400.
- Of the estimated 250,000 uninsured children in Pennsylvania, 71,214 (25.5 percent) are eligible for the no-cost component of the state Children's Health Insurance Program, and an additional 8,265 (3.3 percent) are eligible for the low-cost component of the same program.
- If the funding were made available to enable all eligible uninsured children to be covered by Pennsylvania's public health insurance programs, the Children's Health Insurance Program, and Medical Assistance, 139,425 (55.8 percent) of the estimated 250,000 uninsured children under the age of 18 would have health insurance.

Members of the Pennsylvania KIDS COUNT Partnership include: Pennsylvania Partnerships for Children, the Office of Child Development at the University of Pittsburgh, the Pennsylvania Council of Children's Services, and the Pennsylvania Department of Public Welfare. All partnership activities are supported by a grant from the Annie E. Casey Foundation.

Children Without Health Insurance and Children Eligible for MA

Age Group	Total Uninsured	MA Eligible	%	Non-MA Eligible	%	Total %
Under 6	91,250	33,886	37.1	57,364	62.9	100.0
6-13	101,250	6,686	16.5	84,564	83.5	100.0
14-17	57,500	9,375	16.3	48,125	83.7	100.0
Total Under 18	**250,000**	**59,947**	**24.0**	**190,053**	**76.0**	**100.0**

What this table represents:

- Of the 250,000 Pennsylvania children without health insurance, 59,947 are eligible for Medical Assistance (MA). If these children were enrolled in the existing MA program for which they are already eligible, there could be an immediate 24 percent reduction in the number of uninsured Pennsylvania children.
- There are twice the number of children who are MA eligible in the under 6 age group (33,886) than in the 6-13 age group (16,686). This is of particular concern since prevention of later health problems and developmental delays is critical in the youngest age group.
- Of all uninsured children ages 14-17, 16.3 percent (9,375) are MA eligible.
- Of the 250,000 uninsured children, 76 percent (190,053) remain not covered by MA; some of these children may be eligible for other types of no-cost or subsidized health insurance programs.

Source: Pennsylvania KIDS COUNT Partnership

PRACTICE PARAMETERS NEWS

TREATMENT GUIDELINES OFFERED FOR EAR CONDITION

The U.S. Public Health Service's Agency for Health Care Policy and Research has released treatment guidelines for one of the most widespread health problems in young children—otitis media with effusion—which is characterized by the presence of fluid in the middle ear and often by fleeting off-and-on hearing loss for short periods of time.

Also known to some as serous otitis or "glue ear," the condition differs from acute otitis media in that the child generally does not feel pain or have fever.

The guidelines say that observation or watchful waiting is effective for most children since otitis media with effusion usually disappears within three to six months without treatment.

They also say that antibiotics appear to clear up the condition in a small number of children and should be considered as an option for dealing with the condition during the first three months, but they can also cause reactions such as diarrhea and rashes.

According to the guidelines, if the condition has lasted for three months, and the child has a mild-to-moderate hearing loss in both ears, the options are either antibiotics or a draining of the fluid. Steroid therapy, antihistamines and decongestants, and surgical removal of the adenoids are *not* recommended.

Free copies of "Managing Otitis Media with Effusion in Young Children," a quick reference guide for clinicians, and "Middle Ear Fluid in Young Children," a brochure for parents, are available from the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907; (800) 358-9295. Free single copies of the more detailed clinical practice guidelines are also available on a limited basis.

Pharmacy Recognition

Tobacco-free pharmacies are to be recognized by the State Society through a certificate program this fall. Watch for the certificate in your local pharmacies; more information on the program will be published later this year.

Promoting Living Wills

Maureen Hoepfer

Mary Jo Bonner, MD, PhD, an internist, is a partner in Shillington Internal Medicine Associates, Berks County. For the past 10 years, she has been promoting the importance of advance directives—more commonly known as living wills—to her patients, to the community, and to her colleagues. As chairperson of the Society's Commission on Bioethics, Dr. Bonner played a major role in the Society's negotiations before the enactment of the Pennsylvania Advance Directive for Health Care Act.

The deaths of two prominent Americans—Richard Nixon and Jacqueline Kennedy Onassis—in recent months sparked a burst of national publicity for advance directives. Both Nixon and Onassis had written living wills to ensure their medical wishes would be carried out in their final days. All 50 states have passed legislation recognizing advance directives, including Pennsylvania, which in 1992 enacted the Advance Directive for Health Care Act. However, very few people fully understand what living wills are or what circumstances govern their applicability, according to Mary Jo Bonner, MD, PhD. Fewer yet have taken steps to obtain one.

Patients don't understand living wills

According to a 1993 State Society survey, three in five Pennsylvanians have heard or read about the state's living will statute, although only one in five has actually completed an advance directive. More than half of the survey respondents who have not completed a living will said they would like to do so. Another study conducted by physicians at Thomas Jefferson University in Philadelphia showed that only eight to 15 percent of American adults prepare living wills in advance of the time they can legally rely upon them.

"In my opinion, physicians, especially primary care physicians, need to spend time with their patients and explain the value of signing a living will," says Dr. Bonner. "Misunderstanding is rampant. Many patients are intimidated by the legalese involved with advance directives. They need their doctors to walk them through the thinking and steps involved with drafting a living will. This takes time. It's not a simple statement you squeeze in while checking a patient's blood pressure or monitoring his or her blood sugar. It requires dialogue, conversation, and exchange of information."

Laws authorizing advance directives

As medical technology advances, physicians will be confronted more frequently with legal and ethical issues related to the propriety of withholding or withdrawing life-sustaining support from patients with incurable and irreversible medical conditions. According to Dr. Bonner, physicians can look to two laws for guidance: the Federal Patient Self-Determination Act and Pennsylvania's Advance Directive for Health Care Act.

The federal act, effective December 1991, requires Medicare- and Medicaid-certified hospitals, nursing facilities, hospices, home-health agencies, and pre-paid health plans to provide each patient with written information on the patient's rights under state law to accept or refuse life-sustaining treatment and to formulate advance directives.

Dr. Bonner

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

"As a result of this law, public education about living wills began. People are now notified about their rights and can make informed decisions that can be carried out if they have an advanced terminal condition," Dr. Bonner explains.

In 1992, Dr. Bonner was heavily involved in the drafting of and subsequent negotiations surrounding Pennsylvania's Advance Directive for Health Care Act. This legislation formally authorized advance directives. Under the law, the directive can take two forms: 1) a living will which directs physicians on what treatments a patient wants or does not want should he or she become unconscious or unable to make decisions; or 2) the appointment of a surrogate who may be empowered to make decisions for the patient if he or she becomes incompetent. The living will or proxy designate becomes operative if the patient has an advanced terminal illness and is incompetent or is in a persistent vegetative state. Its activation requires careful clinical assessment.

Drawbacks of living will laws

Although these laws have been effective in educating patients about advance directives and protecting the rights of dying patients, Dr. Bonner says there are drawbacks. "Now that advance directives exist as law, it means there is another area where the government can step in and interfere with the practice of medicine," she explains. "Laws generate rules and regulations that often become inflexible. However, in medicine, we need to be flexible because we are dealing with human beings—each unique in his or her own way."

Dr. Bonner cites two cases which illustrate the inflexibility of the law at times. One is the much-publicized case of Nancy Cruzan, in a persistent vegetative state as a result of a motor vehicle accident in 1983, whose parent's wishes for removal of nutrition and hydration finally prevailed after years of legal battles.

"The U.S. Supreme Court's ruling in the Cruzan case was very narrow," explains Dr. Bonner. "The Supreme Court recognized the individual's constitutional right to refuse medical treatment, but delegated the regulation of this right to the states."

A similar case in Philadelphia also shows the tragic results of court involvement in this issue, Dr. Bonner says. Joseph Fiori, a 21 year old who in 1971 sustained extensive brain damage in a motorcycle accident, later suffered an epileptic seizure that left him in a permanent vegetative state. In 1992, Fiori's mother requested that the nursing home remove her son's feeding tube. The nursing home said it required a court order to do so. The lower court found the mother to be a valid moral surrogate.

Since then, however, the Pennsylvania Attorney General's Office has fought the removal of Fiori's life support, contending that Fiori's mother must prove with "clear and convincing evidence" that Fiori expressed a preference, orally or in writing, for death in this kind of condition. "That means Joseph Fiori would have had to make a declaration about life support 23 years ago when he was only 21. In my opinion, that's unrealistic," Dr. Bonner says. "The Pennsylvania Medical Society has filed an amicus brief in this case supporting the right to withdraw Fiori's life support."

Spreading the word

Education and communication are the keys to avoiding more tragedies like the Joseph Fiori case, Dr. Bonner contends. In Berks County, she has made a personal mission of informing people about the value of living wills. During the past few years, she has given more than 100 presentations about advance directives to community groups, hospital staffs, lawyer organizations, and senior citizen groups.

"The medical and legal professions in particular need to be updated and kept informed about changes in this controversial area," she explains. "I think community forums are particularly helpful because they allow patients, doctors, lawyers, judges, and government officials to openly talk about the issue and the problems confronting them."

Dr. Bonner says she cannot emphasize enough the need to sit down and talk with patients about living wills. She adds that a patient's living will should be reviewed periodically because a person's wishes might change as he or she ages. "There needs to be a good understanding of what the physician can offer, and what the patient expects and wants."

"Unfortunately, what I see happening is that as our society becomes more litigious, medicine is becoming more and more regulated," she says. "There's more and more paperwork involved. What's really tragic is we are becoming so regulated to protect people that we physicians forget that our patients are people. As a result, we risk spending more time with pieces of paper—rules and regulations—than with our patients."

Dignity in Life, Dignity in Death

The Pennsylvania Medical Society distributes a patient information brochure on living wills which explains Pennsylvania's Advance Directive for Health Care Act. The publication describes how to prepare a living will, answers related questions, includes a model living will, and provides a wallet card noting that an individual has written a living will.

To obtain a free copy of the Society's brochure, *Dignity in Life, Dignity in Death,* see page 19 of this issue or call the Division of Communications and Public Affairs at (800) 228-7823. The Society will also send you information on how you can order large quantities of the brochure to distribute to your patients.

Telemedicine Brings High Quality Health Care to Rural Pennsylvania

Imagine a patient sitting in a doctor's office in Wayne County, being examined and diagnosed by a physician more than 150 miles away in Hershey. The diagnosis might include the use of brain scans or MR images or even an ultrasound examination. The physicians and patient see each other and talk back and forth using two-way video and auditory exchange. Is this the "Star Wars" of medicine? Technology of the future? Not at all. It's PA HealthNet, the Pennsylvania Rural Health Telecommunications Network, and it's improving the quality of health care right now.

Penn State's Milton S. Hershey Medical Center demonstrated "telemedicine" this summer with an actual patient consultation between a physician from the medical center and a physician at Wayne Memorial Hospital, as well as with a joint news conference with Governor Robert P. Casey.

"While fresh air and pristine surroundings may be the mainstay of rural life, rural residents are not necessarily healthier than their urban counterparts," according to the Pennsylvania Health Department's Behavior Health Risk Report. For many Pennsylvanians living in rural areas, access to medical care—especially specialized care—is a challenge.

A sophisticated telecommunications network developed by the commonwealth and piloted by the Lackawanna County Medical Society, PA HealthNet is being used to provide health care to rural Pennsylvanians, increase access in underserved areas, and help reduce medical costs.

PA HealthNet is a pioneer in the use of telemedicine, teleradiology, and desktop medical conferencing to:

- conduct remote exams, evaluations, and consultations;
- exchange patient information;
- provide access to continuing medical education; and
- promote communication between rural practitioners and their urban center counterparts.

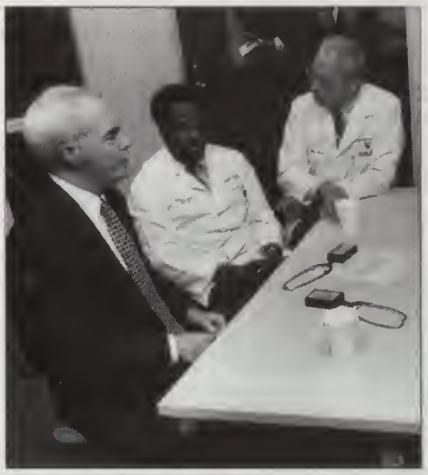
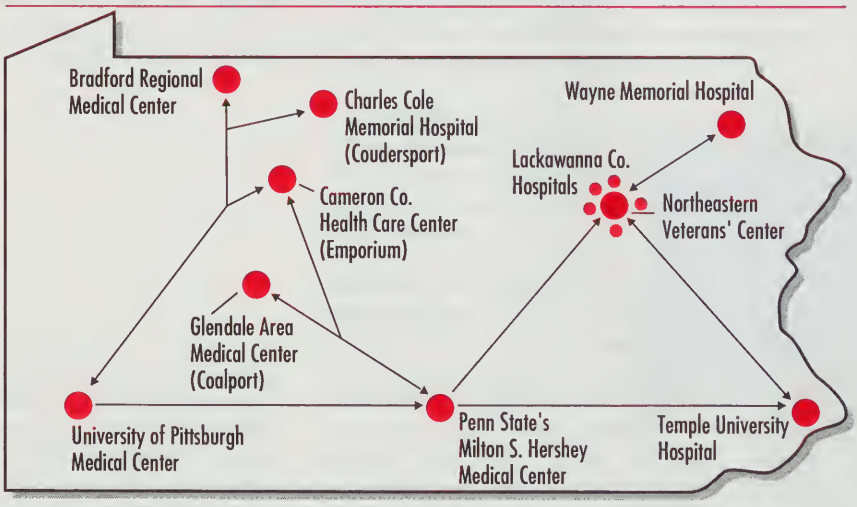


Photo courtesy of Penn State's Milton S. Hershey Medicol Center

Governor Robert P. Casey (left) was given a demonstration of telemedicine this summer at Penn State's Milton S. Hershey Medical Center, by Harold Harvey, MD (center), professor of medicine, and C. McCollister Evarts, MD (right), senior vice president for health affairs and dean of the College of Medicine. Dr. Harvey consulted long distance via PA HealthNet with Marcellus Walker, MD, a physician at Wayne Memorial Hospital, Honesdale.

Pennsylvania has the only state government that has taken the lead in this area of information technology by providing participating hospitals with equipment, and technical and administrative staff support, as well as the telecommunications network. To date, nine telemedicine sites are in place in the commonwealth (see map at left).

PA HealthNet Network



Source: Governor's Office of Administration, Bureou of Automated Technology Monagement

Telemedicine systems are now in place in nine sites across the commonwealth as part of the PA HealthNet project to enhance the quality of health care in rural Pennsylvania by providing a telecommunications link to urban medical centers. The first telemedicine consultations were conducted in January 1994 between Wayne Memorial Hospital and physicians in Scranton.

PHYSICIANS SAY VIOLENCE IS A GROWING CONCERN

Family and societal violence is a growing concern to physicians, according to the State Society's 1994 Membership/Leadership Poll. In last year's poll, members and leaders ranked violence tenth in importance among public health and policy issues; this year, violence was ranked third, behind health care costs and access to care.

The Membership/Leadership Poll is commissioned annually by the Society's Communications Division to:

- determine physicians' opinions of the Society's current activities;
- learn how the Society can better serve its membership;
- identify physicians' practice, public health, and policy priorities; and

• compare physicians' views on various bioethical issues to the results of previous polls.

Reform is priority

Not surprisingly, this year's poll results show that the changes in the health care system and what the Society is doing to represent physicians are most important to respondents. When asked how the Society can serve physicians more meaningfully, and what the Society's priorities should be, physicians overwhelmingly agreed: "Be a strong voice for physicians in health system reform discussions."

Health system reform also topped the list of practice issues of importance to physicians, followed by outside regulation of the practice of medicine, medical malpractice issues, and managed care. Further, more than 84 percent of respondents agreed that patients should be allowed to choose health benefits to fit their needs, rather than being bound to the same health benefit package.

Public health/policy issues

Physicians were also asked to rank the three most important public health and policy issues which the Society should address on behalf of all physicians. As noted, the top three issues were: 1) health care costs, 2) access to health care, and 3) family and societal violence.

Other issues noted include: substance abuse, smoking, child and maternal health, issues surrounding AIDS, bioethical issues, air/water quality, and tuberculosis.

In addition to the rise in concern over violence, the most notable change has been a drop in ranking for "issues surrounding AIDS," which moved from third to seventh since 1992.

The 1994 survey was conducted for the State Society by The Educational and Scientific Trust.

PENNSYLVANIA MEDICINE Recognized for Anti-Substance Abuse Efforts

Governor Robert P. Casey, Attorney General Ernie Preate Jr., and Robert M. Valentini, chairman of the Foundation for a Drug-Free Pennsylvania, recognized 333 media statewide—including PENNSYLVANIA MEDICINE—with a certificate of membership and appreciation for participation in the foundation's Media Partnership, an anti-substance abuse public service announcement campaign.

The foundation estimates that in the Media Partnership's first year, partners donated air time and print space for over 72,000 anti-substance abuse messages valued at $2.2 million. PENNSYLVANIA MEDICINE's most recent effort was an article in the June 1994 issue (page 33) about the foundation's newest program, "Drugs Don't Work Here," which seeks to help employers and labor organizations address drug and alcohol abuse in the workplace.

The Media Partnership was launched in March 1993 with the goal of reaching every community—large, small, urban, suburban, rural—in the commonwealth.

COUNTY NEWS

PHILADELPHIA INSTALLS 133RD PRESIDENT

The Philadelphia County Medical Society this summer installed Thomas G. Gabuzda, MD, associate member of the Cardeza Foundation for Hematologic Research at Jefferson Medical College of Thomas Jefferson University, as its 133rd president.

A native Pennsylvanian, Dr. Gabuzda earned his medical degree from Harvard Medical School. Following an internship and residency at Massachusetts General Hospital, Boston, he served for two years as a captain in the U.S. Air Force, stationed in West Germany. He took research training in hematology in Copenhagen, Denmark, before returning to the U.S.

Dr. Gabuzda is certified by the American Board of Internal Medicine in hematology and in medical oncology. His hospital appointments include chief of hematology, Lankenau Hospital, Wynnewood, and associate staff, Thomas Jefferson University. He also is professor of medicine at Jefferson Medical College.

At the county society, Dr. Gabuzda has been active since 1970 on a number of committees, and he has been a member of its board since 1989. At the State Society, he has served on the Task Force on AIDS and the Commission on Bioethics.

DR. FISHER ELECTED DAUPHIN COUNTY PRESIDENT

Todd Richard Fisher, MD, Hummelstown, has been elected the 130th president of the Dauphin County Medical Society, succeeding Virginia Hall, MD.

Born in Harrisburg and raised in the midwest, Dr. Fisher is a graduate of Muhlenberg College, Allentown, and Penn State's College of Medicine, Hershey. He completed his residency work at Harrisburg Hospital, where he now serves on active staff, and is affiliated with the Family Medicine Center, Middletown. He is board certified in family practice. →

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Dr. Fisher joined organized medicine as a medical student in the mid-80s and is a delegate to the State Society. In the community, he is one of two physicians serving the Middletown School District and is team physician for the school's football team. Also, he is involved in a mentoring-type program with medical students from Penn State's College of Medicine.

Bob McAfee, MD, president of the AMA, was the guest speaker at Dr. Fisher's inauguration. This month, the county society is planning a joint meeting with the Dauphin County Bar Association to discuss health system reform and malpractice reform.

MONTGOMERY COUNTY HONORS RETIRING EXEC

The Montgomery County Medical Society (MCMS) on September 18 held a farewell dinner in honor of U. Berkley Ellis, EdD, its retired executive director.

"Berk has made an enormous contribution to our society," said MCMS President Charles Cutler, MD. "His effort has been tireless. His organizational skills allow the medical society to function as smoothly as it does."

A graduate of West Chester State College and a former school superintendent, Dr. Ellis came to the county society in 1981—the beginning of the "Era of Satisfaction," according to H. Craig Bell, MD, editor of MCMS's *Medical Bulletin*.

"Berk found ways to satisfy the not always reasonable demands, ran a tight ship from a financial standpoint, and hauled MCMS into positions of political power, making our members realize that being the third largest medical group in the state brought clout," Dr. Bell wrote in the September issue of the county journal. "Berk did what was best for the society."

MCMS names new exec

Assuming the role of executive director of the county society is James N. Holton, EdD, a Norristown native and retired school administrator.

Dr. Holton received his bachelor's degree from the University of Michigan and spent two years as an educational specialist in the U.S. Marine Corps, before earning master's and doctorate degrees from Columbia University. He spent 32 years in education, working his way up from teacher and counselor to superintendent. He began his new responsibilities with MCMS at the end of August.

RPS NEWS

COMMUNITY SERVICE RECOGNIZED BY AMA

Two Pennsylvania resident physicians were recognized in June by the American Medical Association for their contributions to community service.

Sarah R. Linde-Feucht, MD, a resident at Lancaster General Hospital, was honored for coordinating in 1993 the 100 Mile Club, a walking and exercise program created for the largely indigent patients of the Family Health Service at Lancaster General Hospital. She also served on the advisory board of Vantage House, a six-month residential program designed to rehabilitate women addicted to drugs and alcohol, and she participates in a program that educates elementary school children about the harmful effects of alcohol.

Dr. Linde-Feucht

J. Lynne Garrison, MD, a resident at the University of Pittsburgh, was honored for her many volunteer activities while in medical school, including serving as an emergency medical technician on the county rescue squad, working in a student-run indigent care clinic, and teaching atherosclerosis prevention to junior high school students. As a resident physician in plastic surgery, she recently worked with a volunteer team of plastic surgeons for two weeks in Vietnam, performing operations and teaching conferences.

Dr. Garrison

Drs. Linde-Feucht and Garrison were two of 40 honorees of the AMA/Burroughs Wellcome Co. Leadership Award Program for resident physicians, which was established in 1988. Awardees attended the AMA Resident Physician Section Annual Meeting in Chicago in June and will have the opportunity to attend the AMA Interim Meeting in Hawaii in December. Also, Drs. Linde-Feucht and Garrison will be invited to sit with the Resident Physician Section caucus at the State Society's annual meeting in Hershey this month.

STATE RECEIVES RWJF PRIMARY CARE GRANT

The Robert Wood Johnson Foundation (RWJF) has awarded nearly $8 million to groups in 10 states—including almost $875,000 to the Pennsylvania Department of Health—to help medically underserved communities recruit primary care health professionals.

The grants are part of the foundation's "Practice Sites: State Primary Care Development Strategies" program, which seeks to help states improve in four critical areas: primary care needs assessment, provider recruitment, provider retention, and financing and policy changes.

According to State Health Secretary Allan S. Noonan, MD, Pennsylvania will use the funds to recruit mid-level practitioners, establish a clearinghouse to match those practitioners with communities, and expand the state's ability to help communities end shortages of primary care providers.

Last year, RWJF awarded the department $100,000—the first phase of the Practice Sites grant—to support the state's comprehensive Primary Health Care Practitioner Program, which includes:

- the designation of shortage areas and matching those areas with available practitioners,
- grants to medical schools and mid-level practitioners' educational programs,
- repayment of medical education loans for professionals who practice in medically underserved communities,
- the governor's School of Excellence in Health Professions for high school students interested in pursuing health and medical careers,

• HealthNet, a rural telemedicine communications system (see page 30), and

• the establishment of area health education centers.

As reported earlier in the year, John A. Malcolm Jr., MD, a Sunbury pathologist, represents State Society physicians on the state's Practice Sites Steering Committee.

TRUST SEMINAR OFFERS RETIREMENT STRATEGIES

Where can a physician receive objective, unbiased financial information, but at the same time not be subject to a pitch man? The State Society's Educational and Scientific Trust recognized the need for this service and is responding by sponsoring a day-long financial planning seminar for physicians and their spouses.

The seminar will be held on Saturday, October 29, at State Society headquarters in Harrisburg, from 9:00 a.m. to 4:00 p.m. The presenter is Ronald J. Paprocki, JD, CFP, vice president, AMA Investment Advisers, LP, an affiliate of the American Medical Association.

Among the strategies attendees will learn are: how to dodge the killer taxes, how to survive inflation, how to engage in safe risk, how much insurance is enough, and how some giving gives back.

To register, call the Trust at (800) 228-7823, ext. 416. The national registration fee for this seminar is $99, but the Trust has made special arrangements with AMA Investment Advisers and is offering it for $59, which includes the workbook and lunch. Physicians are encouraged to bring their spouses at no extra charge. *Registration deadline is October 15.*

NEW DATA BANK RESPONSE OPTION AVAILABLE

Physicians may now respond to any National Practitioner Data Bank report filed against them without going through a formal dispute process, the data bank recently announced.

When the data bank receives a report of an adverse action against a physician, it sends a "Practitioner Notification Document" to the named physician. In the past, the physician would have had to institute formal dispute proceedings to get his or her side of the story on file. Now, a physician may add a statement—up to 600 characters—on the back of the notification, amending the report without activating the dispute process.

The statement is then entered by the data bank, immediately becoming a permanent part of the report, and will accompany the report when released to any approved querying entity. Formal dispute is still an option; however, the new procedure gives physicians more options than previously available.

Excerpted with permission from "Patient Rx Newsletter," September 1994, published by the Pennsylvania Medical Society Liability Insurance Company.

PHILADELPHIA TRAUMA PROGRAMS INTEGRATE

Hahnemann University Hospital and the Medical College of Pennsylvania Hospital have announced the integration of their trauma programs. Under the new arrangement, each hospital will maintain its separate trauma center, but the administration will be combined.

One product of the integration is a new program creating links with Philadelphia-area community hospitals. Referring hospitals will have access to both trauma centers, with bed availability for all trauma transfers. Referring physicians can access immediate consultation on complex emergencies, surgical critical care, and trauma cases through a toll-free trauma hotline, staffed 24 hours a day by an attending trauma surgeon.

Hospitals Receive "Accreditation with Commendation"

Twenty-three Pennsylvania hospitals received "Accreditation with Commendation" from the Joint Commission on Accreditation of Healthcare Organizations for the period January 1, 1991, through December 31, 1993.

The commission accredits approximately 80 percent of the nation's hospitals—nearly 5,300—which account for more than 95 percent of inpatient days in the United States. Accreditation with Commendation—awarded to approximately five percent of hospitals surveyed since the category was established in 1991—recognizes a hospital's exemplary performance in such areas as quality improvement, patient rights, medication use, practitioner credentialing, safety, and organization management. To earn and maintain accreditation, a hospital must undergo an on-site survey by an experienced Joint Commission survey team every three years.

Pennsylvania hospitals receiving the commission's most distinguished accreditation award include:

Abington Memorial Hospital

Bloomsburg Hospital

Bryn Mawr Rehabilitation Hospital, Malvern

Chambersburg Hospital

Chestnut Hill Hospital, Philadelphia

Danville State Hospital

First Hospital Wyoming Valley, Wilkes-Barre

Fox Chase Cancer Center, Philadelphia

Geisinger Wyoming Valley Medical Center, Wilkes-Barre

Germantown Hospital and Medical Center, Philadelphia

Greater Pittsburgh Rehabilitation Hospital, Monroeville

Jefferson Health Services, Pittsburgh

Lake Erie Institute of Rehabilitation

Latrobe Area Hospital

Magee Rehabilitation Hospital, Philadelphia

Meadows Psychiatric Center, Centre Hall

Moses Taylor Hospital, Scranton

Muhlenberg Hospital Center, Bethlehem

Naval Medical Clinic, Philadelphia

Ohio Valley General Hospital, McKees Rocks

Philhaven Hospital, Mt. Gretna

Shriners Hospitals for Crippled Children, Erie

Wilkes-Barre General Hospital

DUR Program Moving Ahead in Second Year

Think of it as a three-stranded braid, wrapped by a fourth strand that holds it all together. "It" is the state's mandated drug utilization review (DUR) program for Medical Assistance (Medicaid) patients. The "braid" includes the three aspects of the program—intertwined, but distinct and separate. The individual strands include prospective DUR, patient counseling, and retrospective review. The strand that wraps around these three activities is the DUR Advisory Board.

In July 1993, PENNSYLVANIA MEDICINE published an article about a unique aspect of the program—the fact that the Pennsylvania Medical Society had sought and been awarded the Department of Public Welfare (DPW) contract for the retrospective DUR strand of the program. The Society is the only state medical organization in the country to hold such a contract.

Over the last year, the Society has been very active in developing an educational program for physicians, including drug information charts included on this page throughout the year. At the same time, DPW has been moving ahead with regard to the other two strands of the program.

This update is designed to provide information about the status of all three aspects of the Medicaid DUR program.

Background

The Medicaid DUR program was mandated under the federal Omnibus Budget Reconciliation Act (OBRA) of 1990, which required all states to develop multi-faceted programs to monitor outpatient medications for Medicaid patients.

The law stipulated that this program be designed to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes. Federal legislators believe such review is useful in improving the quality of patient care and containing government health care expenditures.

While the State Society holds only one contract for this program—the one for retrospective review and education—the Society continues to monitor all aspects of the program as part of its ongoing activities with respect to state programs affecting the medical community.

Prospective review

Nearly every pharmacy in Pennsylvania has now been phased into the electronic claims management system introduced by DPW in June 1993. This first strand of the Medicare DUR program is administered by Electronic Data Systems (EDS), under contract with DPW.

One of the most challenging aspects of this program is the need to distinguish it clearly from the Prescription Assistance Contract for the Elderly (PACE) program of the Pennsylvania Department of Aging.

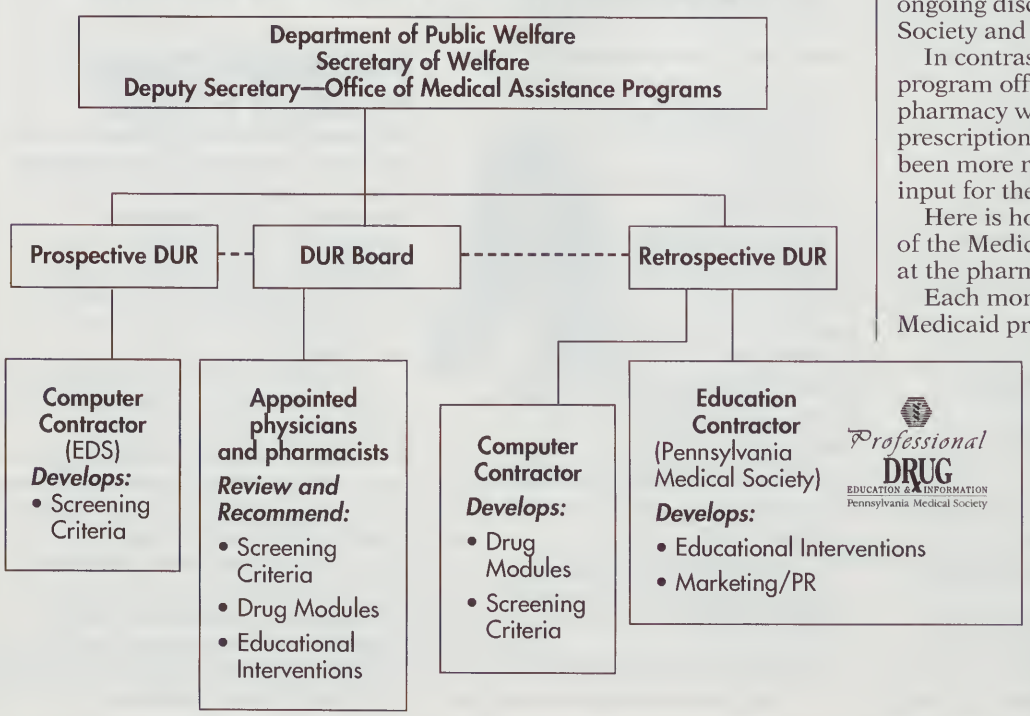
The PACE program, which sets strict parameters on physician prescribing and offers no flexibility to pharmacists in the handling of prescriptions, is the subject of ongoing discussions between the Society and the Department of Aging.

In contrast, the Medicaid DUR program offers flexibility at the pharmacy where a Medicaid prescription is filled. DPW also has been more receptive to physician input for the Medicaid program.

Here is how the prospective review of the Medicaid DUR program works at the pharmacy level:

Each month, thousands of Medicaid prescriptions undergo review through the electronic claims management system. Each time a Medicaid patient has a prescription filled, the pharmacist checks that patient's personal prescription history through the DPW computer network. At that time, an "alert" may be issued by the system for any of a number of

Implementation of OBRA '90 DUR Requirements



reasons, including drug-drug interaction, low dosage, high dosage, early refill, age precaution, pregnancy precaution, or therapeutic duplication. The pharmacist may choose not to fill the prescription, may override the alert on his or her own authority, or may consult with the prescribing physician.

In August, for example, 61,392 of more than 200,000 prescriptions flagged during prospective review were filled by pharmacists after consulting with the prescribing physician. By category, the breakdown was: 24,624 overrides for therapeutic duplication; 13,920 for low dosage; 10,284 for early refill; 7,854 for high dose; 4,640 for drug-drug interaction; 61 for age precaution; and nine for pregnancy precaution.

To reduce the number of false-positives, DPW is making further refinements to the conditions that cause an alert.

Counseling by the pharmacist

Another important provision of the Medicaid DUR statute has to do with the person-to-person contact between the pharmacist and the Medicaid patient.

The pharmacist is required to offer what has been called "counseling" to every Medicaid patient seeking to fill a prescription, regardless of whether that prescription has prompted an alert on the electronic claims management system.

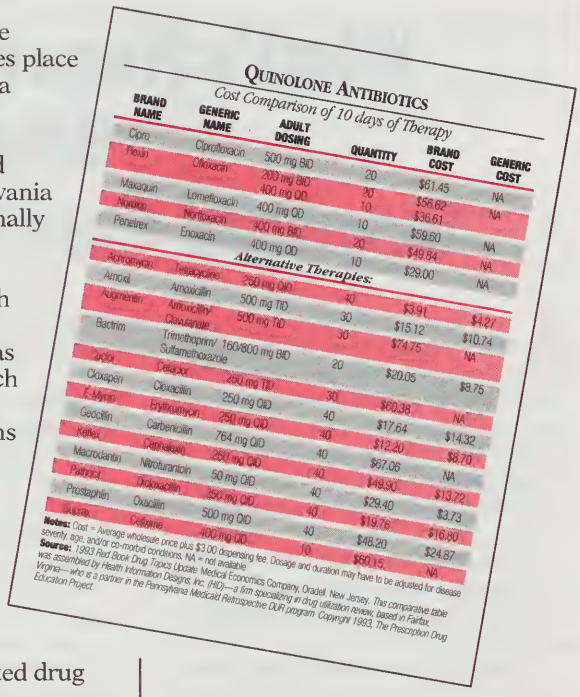
The law says that a pharmacist "must offer to discuss" aspects of the medication or related issues that "in the exercise of the pharmacist's professional judgment," the pharmacist considers "significant." These might include name and description of the medication; administration, form, and duration of therapy; special directions or precautions for use; common severe side effects or interactions, therapeutic interactions, and how to avoid such occurrences; storage; and refill information.

Retrospective review

This component of the program is administered by the Pennsylvania Medical Society's Center for Professional Drug Education and Information. It is important to emphasize that the center's work is educational and non-punitive in nature, and is not tied to the prospective review that takes place at the pharmacy each time a Medicaid patient has a prescription filled.

Center staff have traveled widely throughout Pennsylvania during the past year, personally describing the goals of retrospective review to hundreds of commonwealth physicians.

In addition, the center has conducted intensive research to determine how best to serve the needs of physicians with the educational program. In response to results from surveys and focus groups, the center is producing a series of charts and pocket cards (see sample, at right) comparing costs of prescription drugs by selected drug classes.



QUINOLONE ANTIBIOTICS

Cost Comparison of 10 days of Therapy

BRAND NAME	GENERIC NAME	ADULT DOSING	QUANTITY	BRAND COST	GENERIC COST
Cipro	Ciprofloxacin	500 mg BID	20	$61.45	NA
Floxin	Ofloxacin	200 mg BID	20	$56.62	NA
		400 mg QD	10	$36.61	
Maxaquin	Lomefloxacin	400 mg QD	10	$59.60	NA
Noroxin	Norfloxacin	400 mg BID	20	$49.84	NA
Penetrex	Enoxacin	400 mg QD	10	$29.00	NA
		Alternative Therapies:			
Achromycin	Tetracycline	250 mg QID	40	$3.91	$4.27
Amoxil	Amoxicillin	500 mg TID	30	$15.12	$10.74
Augmentin	Amoxicillin/ Clavulanate	500 mg TID	30	$74.75	NA
Bactrim	Trimethoprim/ Sulfamethoxazole	160/800 mg BID	20	$29.05	$8.75
Doxidan	Doxycycline	200 mg TID	30	$60.38	NA
E-Mycin	Erythromycin	250 mg QID	40	$17.64	$14.32
Geocillin	Carbenicillin	250 mg QID	40	$12.20	$8.70
Keflex	Cephalexin	764 mg QID	40	$67.06	NA
Macrodantin	Nitrofurantoin	250 mg QID	40	$49.90	$13.72
Pathocil	Dicloxacillin	50 mg QID	40	$29.40	$3.73
Prostaphlin	Oxacillin	250 mg QID	40	$19.76	$16.80
Suprax	Cefixime	500 mg QD	40	$48.20	$24.87
		400 mg QD	10	$60.15	NA

Notes: Cost = Average wholesale price plus $3.00 dispensing fee. Dosage and duration may have to be adjusted for disease severity, age, and/or co-morbid conditions. NA = not available

Source: *1993 Red Book Drug Topics Update.* Medical Economics Company, Oradell, New Jersey. This comparative table was assembled by Health Information Designs, Inc. (HID)—a firm specializing in drug utilization review, based in Fairfax, Virginia—who is a partner in the Pennsylvania Medicaid Retrospective DUR program. Copyright 1993, The Prescription Drug Education Project.

The center has added a pharmacist, Brenda Trimmer, RPh, to its staff. A profile in next month's issue of PENNSYLVANIA MEDICINE will outline her role in the Society's activities.

For more information about the Center for Drug Education and Information, contact Barbara Layne at (800) 228-7823.

The wrapping strand

The DUR Advisory Board, also mandated by federal law, is the newest aspect of the Medicaid DUR program. Richard D. Baltz, MD, of Camp Hill, represents the Society on the board, which had its first meeting in June.

The Health Care Financing Administration (HCFA) has been encouraging DPW to consider adding an "alert" for dosages of ulcer drugs in the classification of histamine H_2-receptor antagonists (or H_2 antagonists). This classification includes the brand names Tagamet, Zantac, Pepcid, and Axid. Manufacturers recommend a full dosage for a limited period, followed by reduced dosage as maintenance therapy. This matter was discussed by the board; DPW says it has not yet made a decision about implementing a screening program for these drugs and is proceeding cautiously.

For more information about the State Society's monitoring of the prospective review program and the DUR Advisory Board, contact Jeff Greenawalt at (800) 228-7823.

Barbara A. Layne, the Society's director of professional drug education and information, and Sandra L. Oravec, director of member communications, contributed to this article.

Society Commitment

The State Society has made a series of commitments with regard to the retrospective program. These include:

- to respect the medical judgment of individual physicians,
- to offer continuing education on prescribing standards and practice, and
- to refrain from any activities that could be construed as punitive in nature.

What's Negotiable and What Isn't in Managed Care Contracts

The Health Care Group

Any day now, if it hasn't already, a managed care contract will cross your desk. Whether you're unsure about joining a managed care organization, or whether you've decided the time is right to become a managed care physician, don't sign the contract until you've read and understood everything in it. After you're done reading the contract, ask an attorney experienced in the intricacies and nuances of managed care to review it for you.

Invariably, some provisions in the contract will leave you less than enthusiastic. You may be wondering if you can negotiate a managed care contract. The answer is a resounding yes. The managed care company may not want to change some provisions, but you should always attempt to negotiate those provisions you have any concern about.

Contract provisions that may need to be changed include:

Automatic renewal

This is a standard feature of most managed care contracts. Make certain that renegotiation takes place at least 180 days before the end of the term. This allows you time to review any changes, such as increased memberships, fee changes, or an expanded service area.

Capacity requirements

You may not be able to negotiate this provision, but it's definitely worth trying, or you may be forced to accept unlimited numbers of new patients. Try to include a provision that allows you to say the practice is full to one managed care plan, without requiring the practice to be closed to all managed care plans.

Contract not assignable

Never sign a contract that allows a health plan to assign the physician portion of the agreement to a third party without the physician having the right of prior review and approval of that third party's operations, finances, ownership, etc. This is *absolutely essential.*

Eligibility

Here's another contract provision that's difficult to change, but again, is negotiable. Most plans make it the physician's responsibility to check and verify eligibility every time a member presents for service, and often retain the right to refuse payment or to retroactively take back payments for services if eligibility is not verified.

However, just verifying eligibility does not guarantee payment. Health plans may confirm eligibility, then later determine that the confirmation was in error and withhold or take back payment after services have been delivered. Also, the health plan may conclude that the patient knew when he or she presented that he or she was not eligible and obtained services fraudulently. In this case, it is up to you to bill the patients for services.

Attempt to negotiate a provision that guarantees payment for services rendered in good faith to patients who are later determined to be not eligible, if you follow the proper eligibility verification protocols, and the managed care company gives you incorrect information. Some payers will agree to reimburse physicians who have made a good-faith effort to bill and collect directly from the patient. Usually, two attempts are considered adequate.

Exclusivity

There are two types of exclusivity. In one, the health plan contracts exclusively with a physician or physician group for all members; in the other, the physician agrees to contract exclusively with the health plan and not to service any other managed care memberships. Be very wary of the latter form of exclusivity—tying a practice's survival to a single managed care payer. If you do, insist on being paid a premium for closing your practice to all other managed care plans.

Hold harmless

There are two different sections usually found under this heading. One provision provides that a physician must agree not to bill the member for covered services, other than any applicable copayments or deductibles.

Under the other type of hold harmless provision, a physician is often asked to hold harmless or indemnify the health plan for certain actions. If such language is not negotiated out, you could be subject to litigation for circumstances and acts beyond your control, such as actions of other physicians that directly affect how you are allowed to manage the case. And, malpractice insurance may not protect you.

Incorporated by reference

Often, the contract will say something similar to "...as set forth in the 'Evidence of Coverage' and incorporated by reference and attached as Exhibit 'X.' " It is vital that you read and understand all referenced documents. These should also be physically attached to the contract before signing it.

On-call availability

The agreement should carefully spell out any on-call responsibilities. Make certain you can meet the requirements or supply adequate coverage. Pay particular attention to coverage requirements when you are not available. The agreement may not allow the physician to choose other physicians unless they also have a contract with the plan.

Finally, make certain you are only responsible to provide services within the service area. This holds true for provisions that discuss out-of-area coverage. Also, make sure you are not financially responsible for out-of-area coverage.

Open-ended provisions

Some managed care contracts contain indefinite wording, such as "from time to time," concerning changing contract provisions. Negotiate out any such language. If the managed care plan insists on it, try to negotiate a favorable, no-penalty "out" clause, allowing quick and simple termination if the health plan implements an unacceptable change. Also, require advance written notice of any proposed changes.

Time of payment

Make certain the contract specifies precise timing for payment and contains a provision that physicians be paid interest on late payments. Be specific about payment dates, and negotiate out any wording that allows the payer an opportunity to withhold or delay payments.

For instance, wording such as "The plan will use its best efforts to pay all claims within 30 days of submission," allows the plan to say that it did use its best efforts and list a variety of excuses, real or imagined, for late payment.

Unilateral contract changes

Some contracts allow the plan to change certain terms or conditions. Don't sign a contract that lets the managed care company change the terms without your prior approval. All changes to the agreement should be mutually agreed upon and signed in writing. If the managed care company will not agree to this provision, you should negotiate the right to immediate withdrawal from the contract if you don't agree with the changes made by the managed care company.

Withholds

This is the amount the payer reserves to cover unexpected expenses. Negotiate with the payer to specify exactly how and under what conditions any such reserves should be distributed. The agreement should also specify if the withholds are the limit of each physician's risk or if the physician can be held responsible for losses in excess of the withhold. If the latter is the case, make sure the contract limits the physicians' financial responsibility.

Wrongful denial of care

This provision is a companion to the hold harmless agreement. You must negotiate out any provisions that shift the liability of wrongful denial of care from the plan to the physician.

Remember, never sign a contract that includes provisions you cannot or will not agree to. Although managed care companies may want you to think contracts are written in stone, negotiation is definitely possible and may be necessary to protect your interests.

The contributing author, Joan M. Roediger, JD, LLM, is a lawyer and consultant with The Health Care Group and Health Care Law Associates, Plymouth Meeting.

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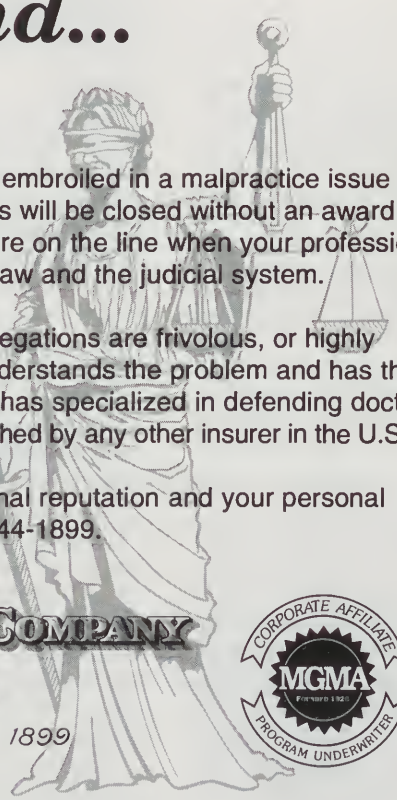

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How to Avoid Getting Kicked by the Media Donkey

David Woods

Being prepared for the media interview will save physicians from embarassment and reverberations after the fact.

After losing the election for governor of California, Richard Nixon told members of the press that they "wouldn't have Nixon to kick around anymore." Well, as we know, they did. But physicians can avoid being kicked by the media donkey if they understand this creature and learn how to treat it with firmness and respect.

First of all, remember that the donkey thinks it's a thoroughbred racehorse and wants everyone to admire it for its fine breeding, configuration, and form. The media want to attract the attention of readers, listeners, and advertisers. Understanding that will help you get through the interview process unscathed.

Increasingly, reporters from the ranks of both print and electronic journalism are seeking out physicians to comment on aspects of health care—both clinical and, more often these days, sociopolitical. How to remain unscathed—or unkicked?

Be prepared. Nothing causes readers to turn the page or listeners/ viewers to switch stations more than dry, rambling responses. You are, after all, the expert. But being the expert isn't enough. Attention spans are contracting while sources of information are expanding, so you should have a very clear idea—in advance of the interview—of the message you want to convey.

Be wary. Ill-considered, off-the-cuff remarks can be ruinous. Keep in mind the absolute finality of the printed or broadcast word. Don't be like the physician who mused, on air, about the desirability of sterilizing all welfare mothers with two or more children. He lived to regret the comment for the rest of his rather foreshortened career in medical politics.

Wariness should extend to realizing that the donkey doesn't only kick defensively; it may do so pre-emptively—even capriciously. What I mean is that *Time* magazine, in its earlier incarnations, would describe an interviewee it didn't like as, say, "portly and aging." It once used those adjectives about a politician who protested to no avail that he was five-foot-nine, weighed 163 pounds, and was in his 50s. Oh, well.

Be clear. Remember that the educational levels of those to whom your message is beamed differ...unless you're being interviewed in a scientific journal. So, no polysyllabic words, arcane references, or medical jargon.

> ***"Physicians can avoid being kicked by the media donkey if they understand this creature and learn how to treat it with firmness and respect."***

Be patient. Interviewers serve as intermediaries between the expert and the audience; they need your help and understanding in order to interpret and present facts.

Be humble. If you don't know the answer, admit it. Far better to acknowledge ignorance cheerfully and openly, than to prove it by hedging and waffling.

Be cool. Aggressive interviewers, or those with particular axes to grind, should not be allowed to wear you down; nor should those who pose the same question in several different ways. Say something like, "A more useful question might be..." rather than, "That's a really silly question."

To avoid the media donkey's kick, understand the creature, be firm, make your intent clear, be confident but wary—and humble enough to know that it is bigger than you.

Media Training Available

Both the Pennsylvania Medical Society and the American Medical Association offer media training for groups and individuals who would like to brush up on their interviewing skills or would like to learn basic techniques. Videotaping can also be included in the training.

For more information, call Amy Dugan, the State Society's director of media relations, at (800) 228-7823 or (717) 558-7750, or Pat Clark at the AMA at (312) 464-4497. The AMA charges expenses.

Mr. Woods, former editor and publisher of the* Canadian Medical Association Journal, *is president of Healthcare Media International, Inc., Philadelphia, and a frequent commentator on health care issues.

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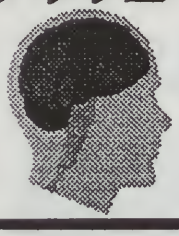

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DATE:

Wednesday
November 16, 1994

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TIME:

3:00 - 3:30 - Registration

3:30 - 5:30 - Workshops

5:30 - 6:00 - Cocktails

6:00 - 7:00 - Dinner

7:00 - 8:30 - Lectures

8:30 - 9:30 - All Panel Discussion

9:30 - Evaluation/ Adjournment

SUBJECTS TO BE DISCUSSED INCLUDE:

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- *Dementia*
- *Headaches*
- *Seizures*
- *Pediatric Neurology*
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Workers' Comp Review: How It's Done

Donald E. Harrop, MD

Initial requests for review of particular workers' compensation cases are sent directly to the Bureau of Workers' Compensation by the employee, employer, or insurer. The bureau then sends them to the utilization review organizations (UROs) by random selection, depending upon the types of review the URO is qualified to perform. Therefore, cases for review may come from any and all workers' comp carriers in the state. This eliminates the possibility of the carrier selecting the URO of its choice and setting any kind of quota or expected denial rate. Of course, the URO must be qualified to do the type of review the particular case in question requires. KePRO is considered qualified to do any kind of specialty review.

Once the URO receives a notice from the bureau identifying the case that requires review, it is up to the URO to request the medical record from the specialist who provided the service, and in some cases, the referring physician. Thirty days are allowed for receipt of the record; if it is not sent, the services in question will be denied according to bureau process.

Upon receipt of the record, the provider is given the opportunity to discuss the treatment plan with a Keystone Peer Review Organization reviewer. The reviewer then renders a decision concerning the reasonableness and/or necessity of the treatment provided. All involved parties may then request a reconsideration of the decision.

In the Medicare process, another level of review would take place before a reconsideration is scheduled. If a reconsideration of a workers' comp case is requested, it is sent directly to the bureau, which then reassigns the case to the URO which performed the initial review. A different reviewer will be utilized to perform the reconsideration review.

As in the Medicare program, the patient is not held liable for payment and cannot be billed for denied services. The one exception would be if the injury/illness is determined by an administrative law judge to be other than employment related.

It will be interesting to see if the Workers' Compensation Act (Act 44 of 1993) has helped resolve some of the problems with workers' comp that we have heard about for the past few years. We hope the Insurance Department or the bureau will soon publish statistics to indicate if the program is working and if workers' comp premiums may be reduced.

Dr. Harrop is president of the Keystone Peer Review Organization.

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OCTOBER 1994

October 19th
New Approaches to Infections in Organ Transplant Recipients
Robert H. Rubin, M.D.
Professor of Medicine
Harvard Medical School
Infectious Disease Division
Massachusetts General Hospital
Boston, MA

October 26th
Treatment of the Geriatric Patient
Joel Posner, M.D.
Professor of Medicine
Director, Division of Geriatrics
Medical College of Pennsylvania
Philadelphia, PA

NOVEMBER 1994

November 2nd
Clinical Diagnosis of Heart Disease for the Generalist
David H. Spodick, M.D., D.Sc.
Professor of Medicine
Cardiology Division
Saint Vincent Hospital
Worcester, MA

November 9th
Thyroid Disorders and the Heart
Paul Ladenson, M.D.
Professor of Medicine
Director, Division of Endocrinology and Metabolism
Johns Hopkins School of Medicine
Baltimore, MD

November 16th
Asthma: Management Strategies
William Busse, M.D.
Professor of Medicine
University of Wisconsin
School of Medicine
Madison, WI

November 23rd
No Grand Rounds—Holiday

November 30th
Kidney Stone Disease
Douglas M. Landwehr, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Nephrology and Hypertension
Allegheny General Hospital
Pittsburgh, PA

DECEMBER 1994

December 7th
Steroid-Induced Osteoporosis
Paul Katz, M.D.
Professor of Medicine, Microbiology, and Immunology
Chief, Division of Rheumatology, Immunology, and Allergy
Georgetown University School of Medicine
Washington, DC

December 14th
Cardiac Auscultation
Leonard S. Dreifus, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Daniel Mason, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Gerald Scharf, D.O.
Professor of Clinical Medicine
Division of Cardiovascular Diseases
Hahnemann University

John J. Ross, R.C.P.T
Research Assistant Professor
Division of Cardiovascular Diseases
Hahnemann University

December 21st
Metabolic Bone Disease - Osteodystrophies and Osteoporosis
Harmut Malluche, M.D.
Professor of Internal Medicine
Chief, Division of Nephrology, Bone and Mineral Metabolism
University of Kentucky
Lexington, KY

December 28th
No Grand Rounds—Holiday

JANUARY 1995

January 4th
Urinary Tract Infections
Donald Kaye, M.D.
Chair, Department of Medicine
Medical College of Pennsylvania and Hahnemann University School of Medicine

January 11th
Antibiotic Resistance
Robert C. Moellering, Jr., M.D.
Shields Warren-Mallinckrodt
Professor of Medical Research
Harvard Medical School
Physician-in-Chief
New England Deaconess Hospital
Boston, MA

January 18th
Aspirin and Warfarin Combined Therapy-Multicenter U.K. Trials
Thomas W. Meade, D.M., F.R.C.P.
Director, Medical Research Council
MRC Epidemiology and Medical Care Unit
Wolfson Insitute of Preventive Medicine
The Medical College of
St. Bartholomew's Hospital
London, England

Prevention and Treatment of Abnormalities of Thrombosis Cardiovascular Disease
Yale Nemerson, M.D.
Goodhart Professor of Medicine and Biochemistry
Chief, Division of Thrombosis
Research, Mt. Sinai Medical Center
New York, NY

January 25th
Complications of Drug Therapy in the Elderly
Michael F. Michelis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital
New York, NY

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

NOVEMBER 16, 1994
Asthma
Guest Lecturer:
William Busse, M.D.

DECEMBER 14, 1994
Cardiac Diagnostic Techniques for the Generalist Physician
Lecturers:
Leonard Dreifus, M.D., Daniel Mason, M.D., Gerald Scharf, D.O., John Ross R.C.P.T

JANUARY 18, 1995
Prevention and Treatment of Abnormalities of Thrombosis in Cardiovascular Disease
Guest Lecturers:
Thomas W. Meade, D.M., F.R.C.P. and Yale Nemerson, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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OBITUARIES

Don L. Bashline, MD, *Grove City*
Temple University School of Medicine, 1943; age 75, died July 12, 1994. Dr. Bashline was a general surgeon.•

Felix Dionisio, MD, *Philadelphia*
University of Santo Domingo, Dominican Republic, 1967; age 53, died July 14, 1994. Dr. Dionisio was a general practitioner.•

Donald H. Haselhuhn, MD, *Camp Hill*
Tufts University School of Medicine, Massachusetts, 1940; age 80, died August 8, 1994. Dr. Haselhuhn was an anesthesiologist.•

Henry T. Kleiner, MD, *Philadelphia*
Hahnemann University School of Medicine, 1949; age 72, died July 10, 1994. Dr. Kleiner was a psychoanalyst.•

Wayne O. McKee, MD, *Beaver*
Hahnemann University School of Medicine, 1943; age 76, died July 12, 1994. Dr. McKee was a general surgeon.•

Alexander S. Vujan, MD, *Venice, FL*
University of Pittsburgh School of Medicine, 1941; age 78, died June 7, 1994. Dr. Vujan was a psychiatrist.•

William H. Walters, MD, *Pottsville*
Hahnemann University School of Medicine, 1945; age 74, died July 17, 1994. Dr. Walters was a general practitioner.•

C. William Weisser, MD, *Pittsburgh*
University of Pennsylvania School of Medicine, 1935; age 84, died April 16, 1994. Dr. Weisser was an ophthalmologist.•

David K. Zierdt, MD, *Carlisle*
University of Pennsylvania School of Medicine, 1960; age 64, died July 6, 1994. Dr. Zierdt was a urologist.•

William D. Allison, MD, *Ardmore*
Temple University School of Medicine, 1950; age 70, died June 20, 1994. Dr. Allison specialized in cardiovascular diseases.

William J. Elwell Jr., MD, *Blue Bell*
Hahnemann University School of Medicine, 1945; age 75, died June 28, 1994. Dr. Elwell was a radiologist.

Harold B. Furman, MD, *Wayne*
Jefferson Medical College of Thomas Jefferson University, 1953; age 70, died June 14, 1994. Dr. Furman was a pediatrician.

Abraham Ginsburg, DO, *Philadelphia*
Philadelphia College of Osteopathic Medicine, 1953; age 74, died June 22, 1994.

Walter W. Jetter, MD, *Greensburg*
State University of New York at Buffalo School of Medicine and Biomedical Sciences, 1931; age 88, died June 29, 1994. Dr. Jetter was a pathologist.

Robert B. Laucks, MD, *Philadelphia*
State University of New York Health Science Center at Syracuse College of Medicine, 1951; age 70, died July 20, 1994. Dr. Laucks specialized in emergency medicine.

Gil E. Pablo, MD, *Jenkintown*
University of the Philippines, 1942; age 77, died July 10, 1994. Dr. Pablo was a thoracic surgeon.

Ralph A. Shaw, MD, *Newtown Square*
Northwestern University Medical School, Illinois, 1962; age 63, died July 20, 1994. Dr. Shaw specialized in internal medicine.

Philip Vaccaro, MD, *Monongahela*
Jefferson Medical College of Thomas Jefferson University, 1925; age 93, died July 30, 1994. Dr. Vaccaro was a general surgeon.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

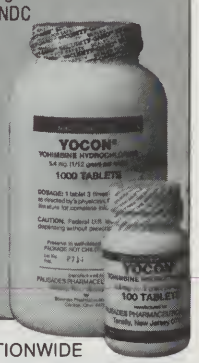
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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NEWSMAKERS

James A. Morris Jr., MD, was one of 15 members of the Delaware County Medical Society who volunteered their time and medical expertise on Sunday afternoons this past summer to provide "check-in physicals" to over 500 campers at Camp Sunshine. Owned and operated by the county government for 60 years, the camp provides overnight camping experiences to children from financially disadvantaged families throughout Delaware County.

The International Journal of Prenatal and Perinatal Psychology and Medicine earlier this year published "The Relevance of the Dread of Being Aborted to Models of Therapy and Models of the Mind, Part One: Case Examples," by **John C. Sonne, MD,** a Philadelphia psychoanalyst.

Peter McCombs, MD, vascular and general surgeon, Abington Memorial Hospital, received the Blockley-Osler Award from Temple University Medical School's 1994 senior class. The award is given to a physician-member of the affiliated faculty of the medical school for excellence in clinical teaching.

Dr. Keenan

Mary Ann Keenan, MD, international expert on neuro-orthopedics, has received the 1994 Commonwealth Board Award from the Medical College of Pennsylvania, Philadelphia, for her significant contribution to the medical profession and community.

Barry Mann, MD, was appointed vice chairman of surgery, Academic Affairs, Medical College Hospitals Elkins Park Campus.

William S. Frankl, MD, regional director, Division of Cardiology, Department of Medicine, Medical College of Pennsylvania, Philadelphia, has received the Edward Lawlor Award. The award—given by the Philadelphia Psychiatric Society—recognizes public service and political action, and was awarded to Dr. Frankl for his role as 1993-94 president of the Philadelphia County Medical Society.

Rodwan K. Rajjoub, MD, neurological surgeon, Williamsport Hospital and Medical Center, was elected to active membership in the Joint Section on Neurotrauma and Critical Care of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

John R. Paluso, MD, director, Emergency Services Department, Mon Valley Hospital, was elected president of the medical staff. Other officers are: **Richard A. Long, MD,** president elect, and **James A. Solan, MD,** secretary/treasurer.

Dr. Walsh

Peter N. Walsh, MD, professor of medicine, biochemistry, and thrombosis research, Temple University School of Medicine, Philadelphia, was the recipient of the University's Sol Sherry Research Award.

William L. Bressler, MD, Huntingdon, was elected a fellow of the American College of Physicians.

Louis W. Catalano Jr., MD, a member of the medical staff, Latrobe Area Hospital, was elected a fellow of the Royal Society of Medicine, London, England.

Temple University Hospital, Philadelphia, has named **Douglas P. Harr, MD,** clinical assistant professor of diagnostic imaging.

The Geisinger Health Care System has appointed **Arthur Sherwood, MD,** senior vice president/medical director of community practice, Eastern Region.

Joseph C. Flanagan, MD, director of oculoplastic service, Wills Eye Hospital, Philadelphia, was elected president of the medical staff. Other officers are: **Edward A. Jaeger, MD,** vice president, and **William E. Benson, MD,** secretary/treasurer.

Temple University School of Medicine, Philadelphia, has named **L. Matthew Schwartz, MD,** clinical assistant professor, Department of Physical Medicine and Rehabilitation.

Stephen P. Dunn, MD, director, Liver and Kidney Transplant Program, St. Christopher's Hospital for Children, Philadelphia, was honored by the American Liver Foundation's Delaware Valley Chapter for his outstanding work in the area of transplant surgery.

Gordon F. Schwartz, MD, a specialist in diseases of the breast, Thomas Jefferson University Hospital, Philadelphia, and a professor of surgery, Jefferson Medical College, Philadelphia, was elected to honorary membership in the Greek Surgical Society during the American-Hellenic Surgical Congress, Athens, Greece.

St. Francis Medical Center, Pittsburgh, has named **Sang B. Park, MD,** chairman of thoracic and cardiovascular surgery, and **Thomas D. Maher Jr., MD,** vice chairman.

University of Pennsylvania Medical Center, Philadelphia, has named **William G. Baxt, MD,** first chairman and professor of the medical center's Department of Emergency Medicine.

Wallace P. Ritchie Jr., MD, professor and chairman, Department of Surgery, Temple University School of Medicine, Philadelphia, has been appointed executive director of the American Board of Surgery.

Dr. Calligaro

Keith D. Calligaro, MD, has been appointed chief of vascular surgery, Department of Surgery, Pennsylvania Hospital, Philadelphia.

Albrecht Schmitt, MD, obstetrician and gynecologist, Chestnut Hill Hospital, Philadelphia, was recognized for his contributions and dedication to the American Society for Colposcopy and Cervical Pathology as one of its founding members and first presidents.

Paul F. Pollice, fourth-year student at the University of Pennsylvania School of Medicine, Philadelphia, has received the Orthopaedic Research Society's New Investigator's Recognition Award for basic science research in orthopedics.

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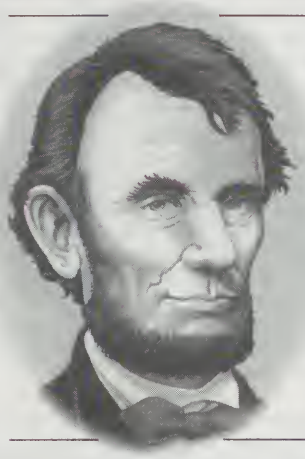

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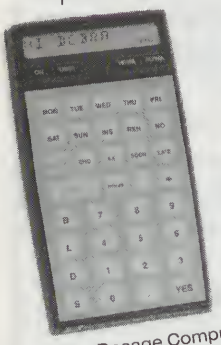

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Separate, But Unequal

Paul A. Kettl, MD

Facing the unfortunate fact that tens of millions of Americans have no health care, the Clinton administration is lobbying support for a revolutionary health plan. This plan, whose keystone is the desire to cover all Americans from serious illness, is now being examined by Congress and the American people. It is doomed to fail.

Failure is assured, not because of economic miscalculation, which I admit I couldn't understand in any event, or even because of partisan politics on Capitol Hill. Rather, it will fail simply because it will not equally insure all Americans.

Before the '92 elections, President and Mrs. Clinton and Vice President and Mrs. Gore supported and signed a petition by the National Alliance of the Mentally Ill to ensure equal insurance coverage for mental illnesses. They promised that mental health coverage would be equal in the new plan to other insurance coverage, giving a glimmer of hope to those who have suffered from illnesses poorly understood, and even more poorly insured by private and public insurance programs. However, only months later, this election promise continues to be only an echo of other election promises, lost in the caverns of bureaucracy. The president still says he wants to provide equal coverage for psychiatric disorders, but it will not come until the next century. In the meantime, there will be insurance coverage, but unequal coverage.

Why? How could the president have reneged on his promise? Could it be that psychiatric care is less effective than other types of medical care, and so is funded less well? Happily, that is not the case, since treatment for many psychiatric disorders, including depression and other affective disorders, have treatment outcomes better than treatment for coronary artery disease, and certainly better than some forms of cancer or AIDS.

Could it be that, if equally funded, everyone would run to a psychiatrist to have something to talk about at the next cocktail party? Of course, that is not the case either. Americans go to the doctor largely when they need to, and it is difficult to arrange more frequent visits for health promotion, illness prevention, or even checkups when they are feeling well.

In federal insurance programs in the past, when funding for all types of care, including psychotherapy, was excellent, only seven percent of employees sought psychiatric care. In my own experience in the Indian Health Service, where Alaska natives paid not a cent for all care—including mental health care and psychiatric care—consultation was obtained only when the patient was suffering. And, thankfully, then it was available.

Could it be that psychiatric care would cost too much? It is no secret that medical care costs money, and that amount has been escalating steadily over the last decade, leading to the proposed new program to control costs. Yet, psychiatrists are among the lowest paid physicians, and psychiatry long ago pioneered using non-physician health providers such as social workers, psychologists, and psychiatric nurses to aid in providing care at a lower cost.

The only reason that remains tenable is that the Clinton administration continues to believe in the stigma surrounding mental illnesses well recognized by those who suffer. The Clinton plan, instead of eliminating this artificial difference as promised, codifies and makes into federal law unequal and substandard health care for those suffering mental illnesses. The plan, designed to make health care available to every American, begins by limiting access to needed care to millions of Americans suffering from severe and potentially life-threatening illnesses.

The administration insists that now we cannot afford equal mental health coverage. So, the new plan would be financed partly by excluding those who may need it most. The health care budget would be balanced by the suffering of those misunderstood by the administration.

The plan, designed to provide equal access to health care to all Americans, fails to provide equal care. We used to lock the mentally ill up in institutions; now, we are locking them out, for literally no reason. It is time to give them the key to equal access to medical care.

"The plan, designed to make health care available to every American, begins by limiting access to needed care to millions of Americans suffering from severe and potentially life-threatening illnesses."

Dr. Kettl is associate professor of psychiatry at Penn State's Milton S. Hershey Medical Center, Hershey.

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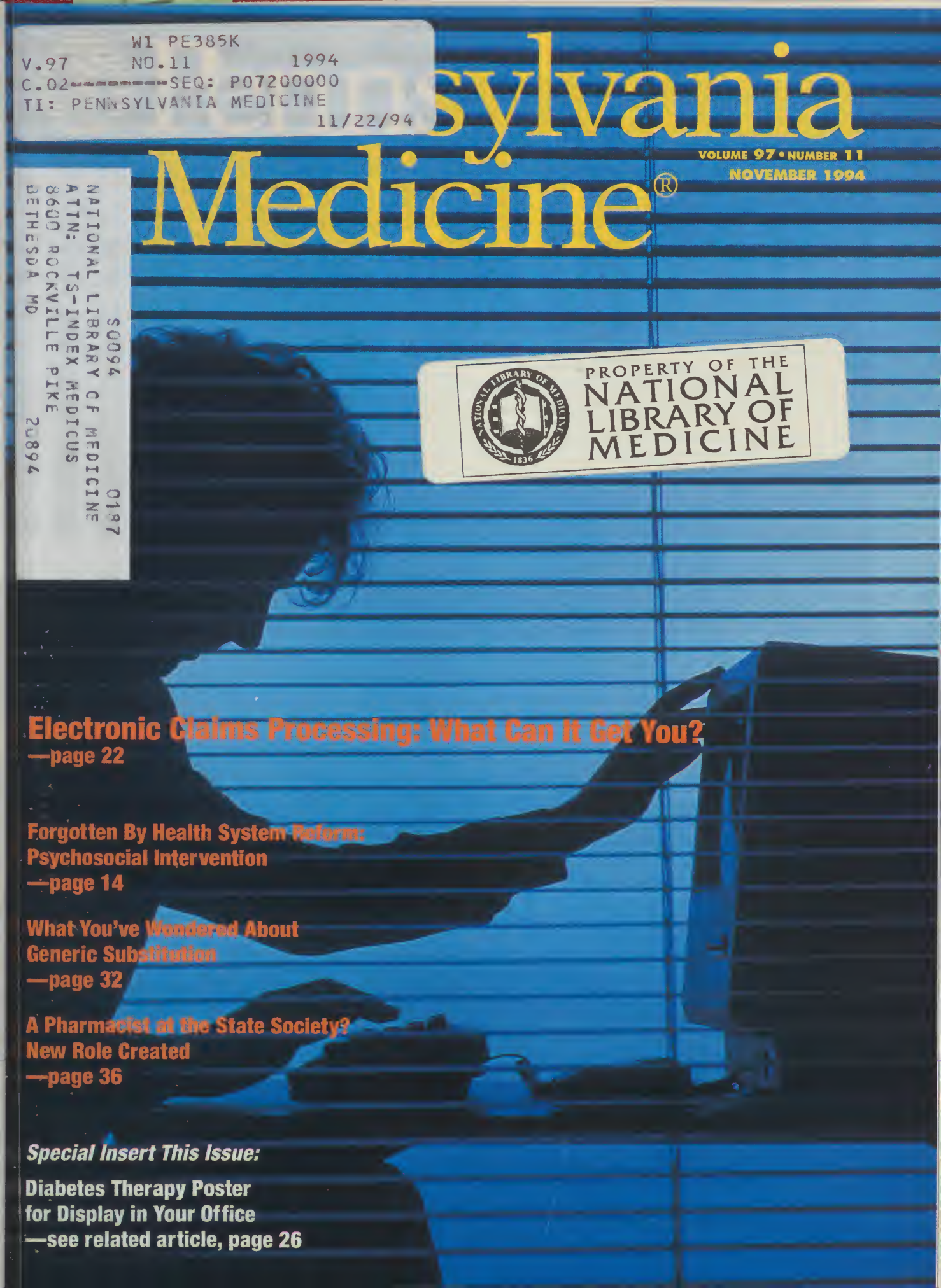

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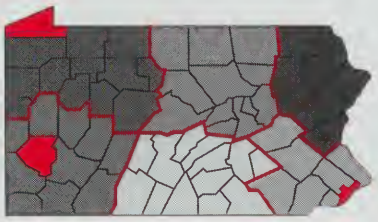

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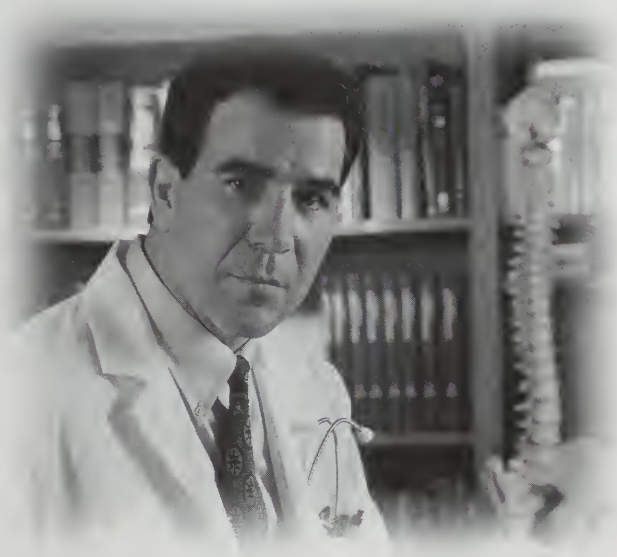

are lucky to have a resource like PMSLIC. I know. Early in my career I practiced in the Midwest. I saw colleagues get burned by a company promising the same medical liability protection for less money. I was pretty young, but luckily I didn't go with them. Unfortunately, my best friend, Phil, did. When his carrier went under, it looked as though a lot of good people would go down with it. Phil just got out by the skin of his teeth. A couple of our friends weren't so lucky. When I came to Pennsylvania, I checked out all my options. Know what? No company can match PMSLIC's record, or offer the same value-added services. Through the years, we've all heard many new carriers guarantee us big savings. But I can't see the value of saving a few dollars in the short run, if it means risking my future. Hey, if you don't believe me, give Phil a call." ❞

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MEDIGRAM

"CHECK TIN NUMBER," BLUE SHIELD WARNS: If you are one of the 4,700 physicians in the state who received a letter from Pennsylvania Blue Shield regarding your taxpayer identification number (TIN), the Society reminds you that the deadline for submitting your revised W-9 form to the carrier is *November 18.* Blue Shield is required by the IRS to withhold 31 percent of future payments to physicians who do not meet the deadline. Direct questions to Blue Shield Provider Data Services at (717) 763-3224.

UNIFICATION SUPPORTED BY HOUSE: The Society's House of Delegates at its annual meeting in October voted by paper ballot not to deunify from the AMA. Resolution 101 (94) called for the Society to allow members freedom of choice regarding AMA membership. Lengthy debate at the Reference Committee on Bylaws focused on several issues, including differences in opinion with AMA policies, declining membership, and the economics of unification. After considering the debate, the reference committee recommended remaining unified, and suggested that the board establish a committee to study the issue of deunification and include results of an AMA Consortium studying the structure of the federation.

"MDP" FOCUSES PRIORITIES, EMPHASIZES MEMBER INPUT: In other action, the House of Delegates approved a new "membership-driven process (MDP)" under which the Society will set its priorities and take action based on the needs and wants of its membership. The process is designed to enhance two-way communication and ensure effective use of State Society resources.

DUES REMAIN AT $430 FOR FIFTH YEAR: The House also voted not to increase Society dues, making it the fifth year in a row dues are set at $430 for the full-dues membership category. Dues remain unchanged for other categories of membership as well. As in the past, $10 of the assessment will be given to the Society's Educational and Scientific Trust.

LANCASTER PLAN APPROVED: The Department of Public Welfare has approved the Lancaster Community Health Plan, a primary care case management program for Medical Assistance patients in Lancaster County. Robert G. Doe, MD, an emergency physician heading the effort along with a board of Lancaster business and professional representatives, reports that the contract became effective October 6. The Society has been assisting Dr. Doe in seeking the necessary approvals and waivers.

STATE NURSING BOARD WITHDRAWS APPROVAL OF DRAFT REGS: The Pennsylvania Board of Nursing has withdrawn approval of draft regulations that would have allowed nurse practitioners to prescribe drugs under guidelines that the Society felt would provide adequate supervision. Reportedly, the nursing board's reversal comes under pressure from the Pennsylvania Nursing Association. The future of this issue is uncertain.

TOLL-FREE HOTLINE OFFERS ANSWERS TO LAB QUESTIONS: The Commission on Office Laboratory Accreditation has announced a new toll-free hotline for physicians and their staff to call to receive "timely" answers to questions about CLIA and other lab-related issues. The toll-free number—(800) 298-8044—is staffed by medical technologists.

CAT FUND PROPOSES 102 PERCENT SURCHARGE FOR 1995: The Catastrophe Loss Fund (CAT Fund) has proposed a 102 percent surcharge to basic malpractice premiums for 1995. The surcharge serves as insurance above the amount covered under basic plans. Final Insurance Department approval is pending.

AMA ACCEPTING APPLICATIONS FOR 1995 ACHIEVEMENT AWARDS: The AMA is now accepting applications for the AMA/Glaxo Achievement Award Program, which provides grants to 25 resident physicians and 25 medical students nationally to attend the AMA National Leadership Conference. The next conference is in April 1995. For more information and an application, call (800) AMA-3211. Deadline is December 16.

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Fall Musings

John W. Mills, MD
Medical Editor

Vivid red fall colors were spectacular as I drove through the Allegheny National Forest on my way home from Rochester, New York, and my fiftieth high school reunion. Still early in the day, I felt surrounded by tranquillity as I covered the miles, unhindered by less than minimal traffic.

It was a perfect state of mind with which to begin a three-week vacation. There was the usual frenetic drive to Pittsburgh airport late in the day, followed by the five-hour flight to San Diego. I was prayerfully thankful for a smooth flight, for I am, admittedly, a somewhat apprehensive flier, accentuated by recent events.

This was to be a special vacation, visiting our oldest daughter, our newborn newest granddaughter and two others, plus the added bonus of our youngest daughter and her husband during the first week. We anticipated being busy and hopefully helpful.

There was another special aspect of this vacation—the San Diego Railroad Museum in Campo, 50 miles east of San Diego. A Baldwin steam engine (a 10 wheeler, circa 1912) is being restored to operating status, and as a member of the crew, I hoped to participate in the action—a lifelong dream.

So as the hours went by aboard my flight, I tucked health system reform, medicine in general, and the Pennsylvania Medical Society, along with the 103rd Congress and "Bill and Hillary," into my subconscious, and contemplated laughter, grandchildren, valve gears, and the majesty of a real, live railroad steam engine.

Reality hit me briefly as my two sons-in-law (local attorney and Pennsylvania physician) met me at the airport. However, the next weeks were essentially free from professional concerns.

Jeans and work shoes set the scene for school bus commuting, grocery runs, piano and riding lesson excursions, all through the mountains of southern San Diego County, 30 miles east of the city and a few miles from the Mexican border. Repair projects were plentiful and welcome, for the physical exercise and challenge to my manual dexterity.

Finally caught up with my grandfatherly pursuits enough to earn a few free days, I was able to spend five days at Campo working on Engine 2353. All work is done by volunteer members, with some expert support from representatives of two steam engine crews from Union Pacific and Santa Fe. It was a 60-mile round-trip each day, a small price to pay for the privilege of being a "hands-on" contributor to the restoration of this marvelous piece of machinery.

I don't think I've ever been so relaxed, so excited, and so absorbed in what I was doing. Don't get me wrong; there have been many exhilarating times and moments in my ob/gyn career and family life. The simple truth of a real vacation is to shut out career, with low-key, yet absorbing activity, to leave one fully rested. It's one of those lessons you learn slowly as you mature.

Unfortunately, many younger physicians don't have the time or where-with-all to give their physical and mental capacities a real rest. I highly recommend such a goal on a regular basis. The ensuing refreshment and rejuvenation are really therapeutic and will certainly help long-term survival.

The pronouncement of death to health system reform by the 103rd Congress didn't escape my notice; it just seemed to be in tune with the calendar. The now brilliant yellow and orange leaves signal nature's preparation for winter's restful sleep.

We have much to be thankful for. The American public couldn't stomach Clinton's "secret" health system reform, dominated by a seven-member, lay health board.

Democracy works—believe it! The marketplace is way ahead of "Bill and Hillary." They'll be back before Springdom (early February—halfway between the shortest day of the year and mid-spring, when days and nights are equal).

For now, enjoy family and any possible vacation from career, share this season of Winterdom, and be thankful for all your blessings.

"The simple truth of a real vacation is to shut out career, with low-key, yet absorbing activity, to leave one fully rested."

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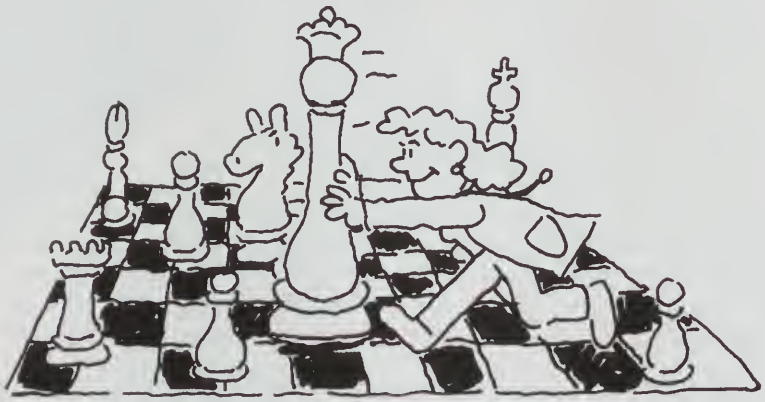

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We're All In This Together

John H. Hobart, MD

Production schedules being what they are, I am writing this column in advance of the 1994 House of Delegates meeting. Claiming no clairvoyance, I am thus writing without knowledge of what has already transpired in several important areas.

You, on the other hand, are reading this after the meeting has occurred, and you know where we stand on the issue of unification, as well as on many other issues that were debated and discussed at the House last month.

I'm not the first physician to look for ways to turn an apparent disadvantage into an advantage. So, I will not use this occasion to react, respond, or comment on what may already be "old news." Instead, I'd like to call your attention to some more or less immutable facts of life for organized medicine—three of the many things you can count on from your state medical society.

You'll never hear us call for divisiveness.
It seems kind of basic, doesn't it? But perhaps you don't realize how basic—and how unusual—medicine's commitment to unity really is. It helps to think about unity in terms of other organizations. In our efforts to affect the course of public policy, we in organized medicine forge many coalitions with those outside of the medical family.

This is a valuable, necessary, and often effective activity on our part. But it is not unheard of for the members of one of these coalitions to abruptly part ways in the midst of the legislative process. No one—not even the members of the coalition—sees this as anything more than necessary self-interest.

Contrast that, if you will, with the bonds we physicians form with each other. To my sorrow, I acknowledge that neither physician organizations nor individual physicians always speak with one voice, and sometimes their parting of ways on an issue may even be a bit divisive. But I can honestly say that no physician or physician organization feels good about it.

And we're never content with divisiveness. We should always be working to build bridges back to each other. In our hearts we know, I think, that it is in all of our best interests in the long run to stand together. The old adage of "united we stand, divided we fall" is every bit as true today as ever.

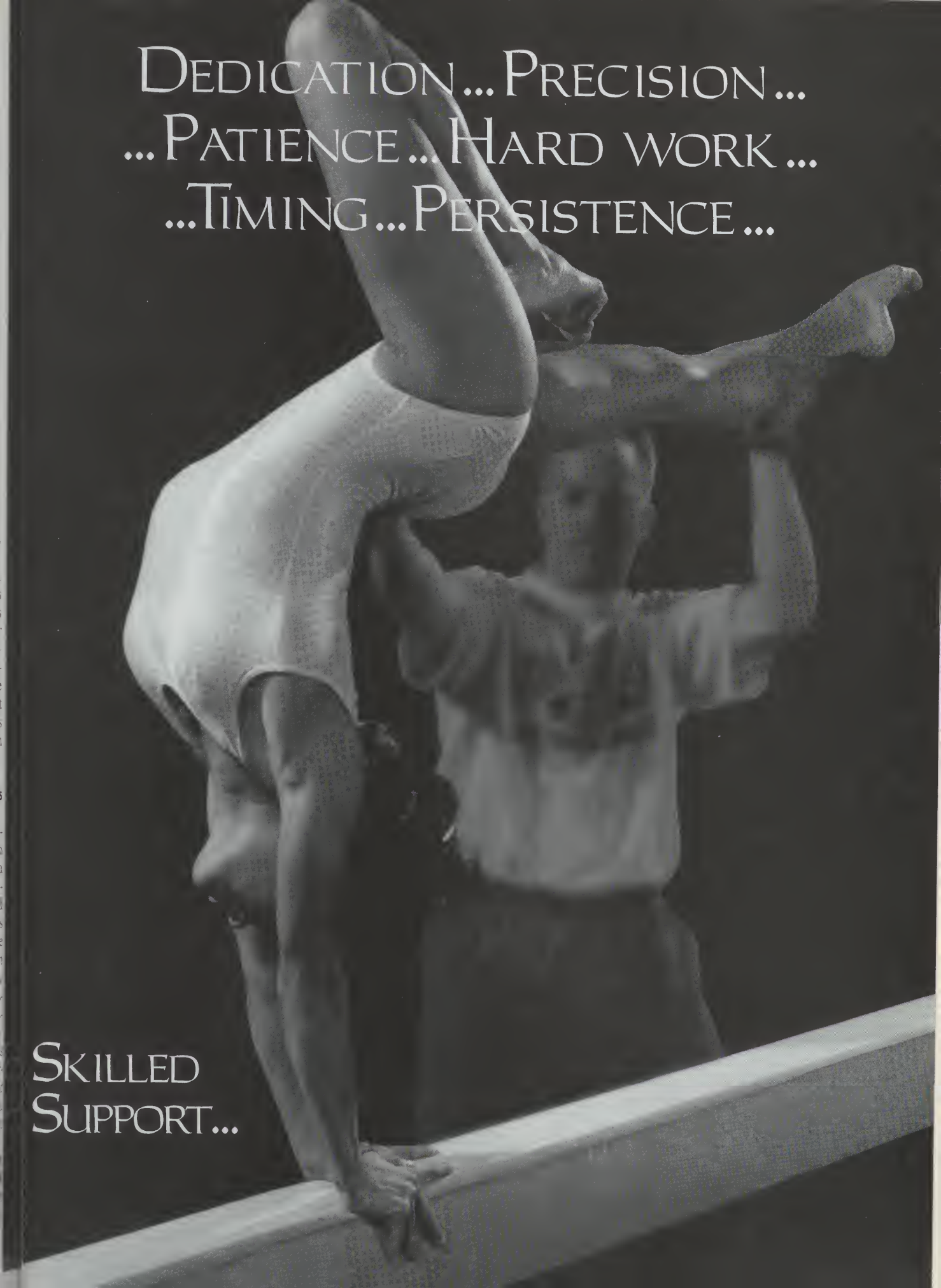
You won't hear us call for a return to the way things used to be.
We know the good old days of medicine, if there ever were any, are gone. It's a different world, and we have to play the hand we've been dealt. There is no value in hand-wringing over loss of autonomy and physician control. It's time for us to roll up our sleeves and start taking what control we can.

This is the whole idea behind our newest subsidiary, the PennMed Member Services Company (PMSCO). Our own research tells us that we must find ways to come together in physician-controlled organizations tailored to our own individual marketplaces—and there are many different health care marketplaces in Pennsylvania—if we want to take control of our future. AMA studies also conclude: Physicians do better when they organize themselves first.

You can count on us to meet the challenges faced by our membership.
Early on I said I made no claims as a clairvoyant. That doesn't mean we can't see into the future. Your State Society is casting a wide net to identify trends before they occur. Already, we can make educated guesstimates about how Pennsylvania's health care marketplaces will change in the next five or 10 years. We have data from places where these changes have already occurred. We are learning from the mistakes—and more importantly, the successes—of physicians elsewhere.

We are creating even more mechanisms to seek out and analyze the salient information that can provide guidance for our future planning. We will be asking you more questions and seeking to learn more from your individual experience.

The world is changing. It always has. But we must not allow the ups and downs of history to fragment our unity or frustrate our efforts to work together for our mutual good.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- **Your Community:** Your county society is a daily presence in your community and in your professional life.
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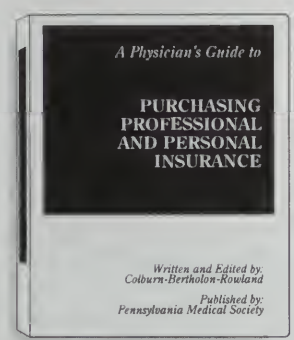

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LETTERS TO THE EDITOR

ACT 44 REDUCING FEES, ADDING PAPERWORK

As a family physician who provides regular health care to a number of patients on workers' compensation, I am becoming fed up with Act 44. Not only has this act reduced our office fees, but it has generated a large amount of paperwork to be prepared at no cost to the insurance companies.

Most recently, I received a request for information from a large insurance company for a patient's one office visit. They asked for admission and discharge summaries; all the treatment notes; diagnosis; estimated length of disability, if any; nurses' notes; itemization of drugs; present and past health history; prognosis; and diagnostic tests. They claim that no authorization was required for all of this information to be released because of provisions of Pennsylvania's Workers' Compensation Act.

This type of letter is quite common amongst the insurance companies now, and the requested documentation is to be prepared at no cost to the insurance companies to my knowledge. I do not know how it is possible to both see patients at the reduced rate, plus prepare all of this information at no cost, yet still run a business. In the case of this patient, to prepare all of this information would take about 20 minutes.

I am sure many other family physicians find themselves in a similar predicament.

What can our Society do to help either reduce the paperwork load or get payment for services rendered? I would appreciate the Society's response to this question.

Thomas W. Andersen, MD
Mount Joy

Response: The State Society has been working to point out exactly what Dr. Andersen is speaking of—that third-party requests for medical information should be case specific and relevant to the issue at question, not "fishing expeditions." Society efforts continue with workers' compensation and auto insurance regulations, and more recently the Society addressed legislation dealing with the costs of copying medical records.

A reminder to all physicians: Physical medical records belong to the provider, and relevant medical information contained in the records belongs to the patient. If a third-party payer wants information on a specific service, it should ask for it.

For more information, call Don McCoy, the Society's director of regulatory affairs and specialty legislation, at (800) 228-7823 or (717) 558-7750.

Your Letters Are Welcome

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Letters should be typed or legibly handwritten, concise, and should not exceed 200 words.

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1994-1995 Continuing Education Programs

Update in Pediatrics
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2nd Annual Emergency Medicine Seminar
Friday-Sunday
November 18-20, 1994
Outer Banks, NC

Advanced Trauma Life Support Provider Courses (ATLS)
Friday & Saturday
January 20 & 21, 1995
OR
March 10 & 11, 1995

Advanced Cardiac Life Support Renewal Course
Wednesday
February 1, 1995
OR
Wednesday
March 15, 1995
OR
Wednesday
May 10, 1995

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Friday-Sunday
February 10-12, 1995
Danville Days Inn

Contemporary Issues in Internal Medicine
Wednesday
March 8, 1995

Cutaneous Surgery
Friday
March 17, 1995

Primary Supportive Care for the Cancer Patient
Friday
March 24, 1995

Advances in Dermatology
Wednesday
April 5, 1995

Annual Thoracic Medicine Seminar
Wednesday
April 19, 1995

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Wednesday
May 3, 1995
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Wednesday
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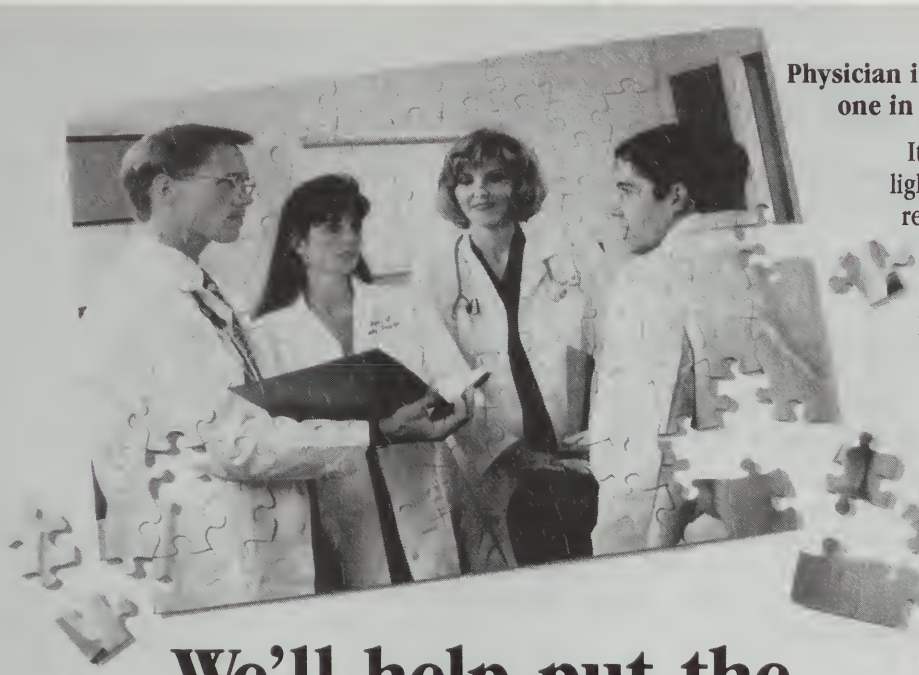

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Clinical and Cost Effectiveness of Psychosocial Interventions in Health Care

Michael J. Asken, PhD
David W. Florence, MD, MPH
James M. Walker, MD
Lee C. Miller, MD

Physicians should recognize the importance of the psychological care of medical patients and not let it be pushed aside when the health system reform debate re-emerges next year.

From the ancient Greeks to the contemporary disciplines of behavioral medicine, health psychology, and consultation-liaison psychiatry, there has been the recognition by medicine of the important relationship of psychological and physical factors in health and illness.[1] Despite this, anticipated changes in health care are creating an environment in which the role for the *psychological care of medical patients* is in danger of being neglected in favor of the multiple needs competing for the pole position in the health care reorganization race.

Saravay and Strain observe that a lack of outcome studies on consultation-liaison psychiatry issues and interventions has resulted in the fact that "...the scope and effect of psychiatric disorders in medically ill persons have not been appreciated by our medical colleagues or by health care administrators or policy makers."[2]

This seemed particularly true as one tried to decipher various health system reform proposals with regard to provision of psychological services to medical patients. The content of the Clinton plan did not seem to clearly specify such services. Further definition of services at the state and federal level would complicate the picture even more and may result in exclusion of certain services, providers, or untenably low reimbursement rates.[3,4]

While the general assault on mental health coverage is misguided, the failure to designate specific psychosocial services for medical patients may be especially counterproductive. Cost-effective treatment of medical patients often requires skillful management of psychosocial problems.

The authors are affiliated with Polyclinic Medical Center, Harrisburg. Dr. Asken is clinical/health psychologist, Department of Rehabilitation Medicine, and teaching faculty, Internal Medicine Residency Program; Dr. Florence is vice president of medical affairs; Dr. Walker is staff physician and teaching faculty, Internal Medicine Residency Program; and Dr. Miller is staff psychiatrist and in private practice in Harrisburg.

Strain, Hammer, and Fulop report three essential observations with regards to the "psychology" of medical patients: 1) psychiatric and medical problems often coexist in the general medical ambulatory and inpatient setting; 2) health service utilization is increased with co-morbidity; and 3) psychosocial interventions can affect not only psychiatric morbidity but the cost of medical care as well.[5]

A sampling of several factors—including the broad and growing evidence for the frequency of significant psychosocial issues in medical populations, the influence of psychosocial factors on treatment course and clinical outcome, the impact that psychosocial interventions have on outcome, and the cost offset effects of providing such interventions—will show the importance of providing psychological/psychiatric interventions to medical patients in both the ambulatory and inpatient medical settings.

Frequency of psychological problems in medical populations

The Virginia Study by Marsland, Wood, and Mayo—a landmark in demonstrating the prevalence of psychological problems in primary care—found anxiety and depression to be among the 15 most frequent diagnoses made by family physicians.[6] A survey of directors of family medicine departments and family practice residency programs found that the directors reported that only 45.2 percent of patients were seen for purely "medical" problems, with the rest having an important psychosocial component to their presenting problems.[7]

From a different perspective, Florence and Asken recently discussed the presence and role of psychosocial factors in chronic pain and long-term disability.[8] Smith has discussed the increasing recognition of somatization disorder in medical patients, its influence in the overuse of medical resources, and its impact on health care costs.[9]

The medical effects of psychological problems in hospitalized medical patients and their extension to the post-discharge environment have also been documented. Schleifer and colleagues assessed the presence of depression in 283 patients admitted for myocardial infarction at two urban teaching hospitals. Assessed eight to 10 days post-MI, 45 percent met the diagnostic criteria for major or minor depression. At three to four months post-event, 35 percent continued to meet the criteria for major or minor depression.[10]

The incidence of depression in stroke patients has been reported at 26 percent, six months post-insult.[11] In general, depending on the setting and assessment methods used, rates of depression in medical outpatients range from five to 25 percent, and in the inpatient setting, rates of depression range from 15 to 33 percent.[12]

Treatment course and clinical outcome

Psychological factors have a broad impact on medical patients, from affecting willingness to accept screening, to compliance with prescribed treatment, to influencing decisions regarding hospital admission, to the course of treatment and clinical outcome.

Strain, Hammer, and Fulop reviewed three studies which concluded that psychosocial factors were related to admission decisions and to length of stay. In one study, 11.8 percent of hospital days could not be accounted for by physical needs. A second study found 18 percent of hospital days were secondary to social rather than purely physical problems, and a third study found that social factors were critical to the decision to admit in 21 percent of cases.[13]

Frasure-Smith found that patients hospitalized for myocardial infarction, in whom high levels of distress were identified one to two days pre-discharge, but who were treated with routine (non-psychological) care, demonstrated a 1.5-fold increase in reinfarction and a three-fold increase in risk of cardiac mortality compared to other patients. Return to work in patients with moderate or slight-to-moderate impairment after myocardial infarction has also been found to be significantly affected by psychosocial problems.[14,15] Depression, anxiety, and poor coping skills are associated with a low probability of return to work. Feibel and Springer found post-stroke depression to be significantly correlated with failure to resume premorbid activities.[16]

Returning to length-of-stay and related utilization factors, Saravay and Lavin recently reviewed 26 studies on psychiatric co-morbidity and length of stay for medical/surgical patients. They reported that whether conclusions were drawn from all studies available or only those "more recent rigorously controlled studies," co-morbidity contributed to prolonged length of stay and greater utilization of hospitals and other health care resources after discharge. Significant co-morbid conditions were impaired cognition, delirium, dementia, depressed mood, and personality disorders.[17]

Anticipating changes in health care delivery systems, a comparison of managed care and more traditional approaches found no difference in the presence of depression among patients in the different systems. Prepaid health plans did rely more on general medical practitioners to provide mental health care than psychiatrists, and the detection rates of depression were lower in pre-paid settings.[18]

Impact on outcome

The effects of psychological factors in medical care are clear. The next question is whether psychosocial and psychotherapeutic interventions result in improved outcomes.

It has been reported that, as early as 1934, Billings was involved with consultation-liaison services on a medical/surgical unit of a general hospital at the University of Colorado. Earlier discharge and improved psychosocial status of patients was described.[19] The same authors described a contemporary psychosocial screening and intervention program for elderly patients with hip fractures. The study was conducted simultaneously at two medical centers. At Mt. Sinai Hospital in New York, the average length of stay was reduced by 2.2 days with the program, and at Northwestern Memorial Hospital in Chicago, average length of stay was reduced by 1.7 days.[20]

The effectiveness of psychosocial interventions for addressing issues in surgical patients has been demonstrated in many studies. A typical example is that of Egbert and colleagues who found that appropriate psychological preparation of surgical patients reduced post-operative pain and post-operative narcotic use by 50 percent. Patients were judged ready for discharge approximately two days sooner when treated with psychological preventive and interventive strategies.[21] Work in this area led Olbrisch to conclude almost 15 years ago that "the effectiveness and economic efficiency of psychotherapeutic preparation for surgery are strongly supported."[22]

→

"The effectiveness of psychosocial interventions for addressing issues in surgical patients has been demonstrated in many studies."

As a final example of efficacy, the work by Frasure-Smith is again noteworthy for demonstrating the influence of psychosocial interventions on clinical outcome. In addition to finding significant rates of depression and adverse impact on outcome in post-infarction patients, she reported that highly distressed post-infarct patients who took part in a stress monitoring and intervention program showed no increase in morbidity or mortality as opposed to highly distressed post-infarction patients in the "regular care" protocol.[23]

The positive effect of psychosocial interventions in outpatient medical settings has been reported as well. Follette and Cummings found that individuals with high emotional distress were high utilizers of medical services. Further, even brief or single-session psychotherapeutic intervention led to decreased utilization rates. They concluded: 1) medical service use decreased significantly in psychotherapeutically treated versus non-treated groups; 2) the decline in use was maintained for five years after psychotherapeutic treatment was terminated; and 3) psychotherapeutic costs did not merely supplant medical costs.[24]

Rosen and Wiens reported similar results from psychological interventions. They found decreases in the number of: outpatient medical visits, days hospitalized, prescriptions written, emergency room visits, and diagnostic studies.[25]

Concern about medical costs has been the impetus for corporate and industrial preventive medicine and wellness programs. Approaches such as those used at General Motors or the Kimberly Clark Corporation have shown an ability to decrease medical costs.[26]

Surveying the available data, Cummings concludes, "The evidence thus far suggests that psychological services can reduce the inappropriate utilization of expensive medical care among the 'worried well' and improve medical management and behavioral outcomes among the chronically ill."[27]

Cost offset effects

A final concern that has special urgency in today's health care climate is whether these effects of psychosocial intervention translate into cost savings or simply become a layer of added expense.

Billings is noted to have provided data showing a decreased length of stay in medical patients with liaison services from 28 to 15 days. This translated into an avèrage total savings per patient of $43 dollars. (Per diem at that time was $4.)[28]

Psychosocial interventions with hip fractures described by Strain, Hammer, and Fulop were reported to have saved Northwestern Memorial Hospital a total of $97,361. A Social Risk Program at a different hospital was described by the same authors as reportedly demonstrating a cost savings of $1,096,802 in 1991.[29] This was equivalent to a return of $48 saved for every dollar spent. Finally, Cummings concluded that the impact of behavioral medicine interventions on hospital costs translated into $5 saved for every $1 spent.[30]

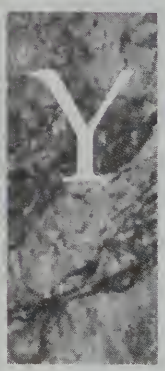
"Inclusion of psychosocial services for medical patients is necessary, cost effective, and good medicine."

The foregoing has been an attempt to represent the clinical and economic importance of psychological factors in medical care. Certainly there are variations in the quality of studies. However, while additional studies will be useful, there is currently enough good data to continue development and research into effective interventions.

With the emerging dominance of managed care arrangements in American medicine, practitioners and insurers will be sharing the financial risks of providing capitated services. This means that both practitioners and insurers need to know which patients can be expected to derive cost-effective medical benefit from interventions intended to improve their psychosocial functioning.

The next step is to continue to identify these groups, confirm the medical effectiveness and cost effectiveness of specific psychosocial interventions, and build the resulting recommendations into practice guidelines. Inclusion of psychosocial services for medical patients is necessary, cost effective, and good medicine. ⬡

References available upon request.



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PETERSON OFFERS RURAL VIEWPOINT ON REFORM

While the *New York Times* heralds its death on the front page, health system reform continues in good health on the state and local pages of newspapers statewide. In Pennsylvania, the rural viewpoint weighs heavily in the debate. Representing the commonwealth's largest and most rural Senatorial district, Senator John Peterson (R-Venango) has continued to focus on the need for extensive reform of the state's health system, despite the death rattle of nationwide efforts.

In his videotape presentation viewed early this fall by the State Society's Council on Governmental Relations, Senator Peterson said that there are few incentives for cutting costs in our current system. "More changes are occurring now from within the system than ever before because of the threat of reform," the senator said, emphasizing that the Clinton plan would "change almost everything" while accelerating costs. He says that the Casey plan is similar to the Clinton plan: "It gives awesome power to a nine-member board to develop a plan, to implement a plan, and to handle the money. With a $40 billion dollar budget, this board would instantly become the largest corporation in the history of Pennsylvania, a corporation that will control all of our health care needs. I don't know about you, but I don't want another bureaucracy interfering in my daily life."

Crucial to making the current system cost effective, he says, is prevention and wellness education, especially in such areas as drug abuse, interpersonal violence, and smoking. To coordinate these programs, he recommends creation of an Office of Physician General.

Among the functions of that office, he says, would be advising the legislature on more effective and efficient use of primary care providers: "Emphasis needs to be placed on training more primary care physicians and increasing the availability of mid-level providers, such as physician assistants, nurse practitioners, and nurse midwives to provide primary and preventive care." He advocates expanding the scope of practice for "mid-levels who are trained and capable of treating nearly 80 percent of the patients who visit a primary care doctor."

To ensure quality care, Peterson would require board certification for all specialties and subspecialties, and mandate continuing medical education.

Computerization of medical records, with the use of "PIN" numbers similar to bank access cards, would improve quality care and eliminate duplication of testing, he believes. Because physician ownership of labs and equipment increases unnecessary utilization and contributes to costs, he says, "We need to stop it as soon as possible."

Senator Peterson

"More changes are occurring now from within the system than ever before because of the threat of reform."

Senator Peterson includes tort reform as a necessary step in reform. Pennsylvania has made no changes in the law of torts in the past 20 years, and he emphasizes that "to be successful, support must be broad based with the medical community, business community, labor, service providers, and financial institutions joining hands to make changes in malpractice liability." The senator adds, "In our efforts to improve the health care system, we can't stop with tort reform but must reform our third-party payer system. The insurance industry agrees that we must provide continuity, reduce the number of uninsured, and lower health insurance costs. We need to guarantee issuance, require portability, prohibit pre-existing condition clauses, and include preventive care." He advocates allowing pooling of health care purchasing by small businesses.

Along with insurance reform, he would require a co-payment which could be discounted for healthy lifestyles, institute medical savings accounts, redefine basic coverage and create a special fund for research and experimental procedures, and simplify insurance forms.

Senator Peterson concludes, "We have the best health care system in the world, and it doesn't need a complete overhaul...We can fix our current system, but we must begin now or we will get a new system no one wants."

PHYSICIAN DE-SELECTION SUIT DISMISSED IN TEXAS

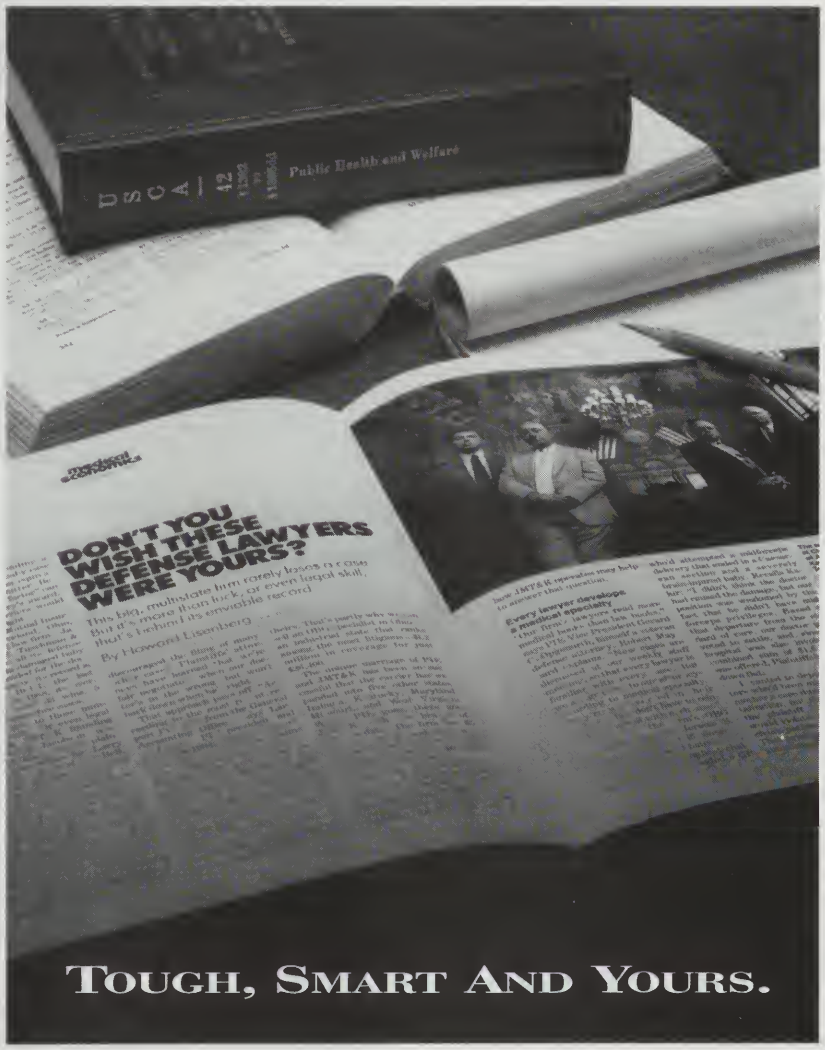
Editor's Note: This article is excerpted from the AMA's Electronic Network.

In a setback to physicians and managed care rights, a Texas federal judge dismissed a lawsuit challenging de-selection of Houston-area physicians by Aetna Health Plans. The plaintiffs in the case were five Houston physicians, the Harris County Medical Society, and the Texas Medical Association.

The lawsuit arose from Aetna's decision last September to de-select 37 physicians from its Houston-area preferred provider organization (PPO) network of more than 2,000 physicians. Sixteen of the 27 physicians who appealed the decision by Aetna have subsequently been reinstated.

The district court ruling reinforced the Texas Department of Insurance's ability to enforce rules regarding managed care plans, but indicated that physicians could not sue the insurers who do not follow those rules. The plaintiffs plan to appeal the U.S. District Court's decision to the Fifth Circuit Court of Appeals.

For more on Society efforts related to the "any willing provider" issue, see "Any Willing Provider Language Approved," page 20.



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ACTIONS OF THE BOARD OF TRUSTEES, SEPTEMBER 13-14, 1994

ANY WILLING PROVIDER LANGUAGE APPROVED

Exclusion of providers from managed care contracts is a major issue—and a controversial one—among Pennsylvania physicians. At its September meeting, the Society's Board of Trustees attempted to clarify its position on the complex "any willing provider" debate.

The current policy, adopted by the 1993 House of Delegates, requires the Society to include in its health system reform position "the concept that any willing health care provider/supplier be permitted to participate in health care networks/alliances, provided they meet basic quality assurance criteria."

To date, the any willing provider debate in Pennsylvania has largely focused on the two extremes. At one end, proponents of strict any willing provider legislation say networks should be required to admit any licensed provider willing to accept the plan's payment terms. At the other end, opponents say that networks should have unfettered discretion regarding who is admitted to a network.

The Society's board believes there is a middle ground, and that the interests of the *core* of the Society's membership and their patients will be best served by a solution that recognizes the legitimate concerns of both sides. Thus, the board is committed to re-focusing the debate in the commonwealth and obtaining legislative safeguards that preserve the Society's three system reform goals of access, quality, and freedom of choice.

With this in mind, the board presented five specific recommendations to the House of Delegates at its October meeting:

1) The Society should endorse AMA positions advocating selection criteria based on professional competence and quality of care, due process, and physician input from a network "medical staff" regarding both the criteria and the process.

2) Managed care networks should not be permitted to require physicians to have hospital admitting privileges in those areas of the state where it is impractical for the physician to maintain such privileges or where such a requirement could aggravate a physician shortage.

3) Managed care networks should be required to waive board-certification requirements in areas where such a requirement could aggravate a physician shortage.

4) The Society should seek legislatively mandated safeguards to protect providers from arbitrary exclusion from managed care networks.

5) The Society should reiterate its position that individuals must be free to choose from a full range of health care coverage plans, and should not be forced into a plan that limits their choice of provider or misled into selecting such a plan.

Follow-up of House action on these recommendations will be included in annual meeting coverage next month in PENNSYLVANIA MEDICINE. For national news on the any willing provider issue, see "Physician De-Selection Suit Dismissed in Texas," page 18.

LEGISLATION WOULD EASE DUAL ACCREDITATION SYSTEM

The Society is hoping to ease compliance for physicians' office laboratories now struggling under the commonwealth's dual system of laboratory accreditation.

Currently, Pennsylvania physicians with office labs must comply with both federal and state regulations of accreditation. But the Society's Council on Education and Science maintains that the problem "could easily by resolved" if the federal government and the state Bureau of Laboratories both accepted the standards of the Commission on Office Laboratory Accreditation as equivalent to their standards. The Health Care Financing Administration announced late last year that it would grant "deemed status" to the Commission on Office Laboratory Accreditation, but the state Department of Health still does not recognize the commission's standards.

Board action in September directs the Society to seek state legislation to require the bureau to grant deemed status to the commission. Until such time, enrolling through the commission will not relieve physicians of dual accreditation.

Other actions

Other board-approved recommendations of the Council on Education and Science direct the Society to:

• *Assist physicians in assuring that patients' wishes concerning levels of care are followed.* The board approved as policy new level of care guidelines, developed by the Society's Commission on Bioethics, which has determined that "changes in thinking rendered the concept of DNR [Do Not Resuscitate] orders obsolete." Commission members noted that such orders can't be viewed as "all or nothing," but instead, "physicians must be prepared to customize the orders to more exactly match the patient's wishes."

• *Be prepared to suggest changes to the Medical Practice Act of 1985, should the act be reevaluated next year.* Though the 1985 act was originally slated to expire in 1995, sunset laws were recently ruled unconstitutional, and such laws are now prohibited from expiring. However, legislators may still scrutinize the law and make changes, and hearings on the Medical Practice Act are expected. Society suggestions address peer review, licensing of international medical graduates, drug addiction, and disciplinary actions, among other topics, and incorporate Society House of Delegates mandates.

• *Reaffirm its continuing medical education (CME) requirement for Society members*—Following a suggestion that the Society drop its CME requirement for membership, the council studied the issue and cited a number of reasons not to drop the requirement, including that "education is clearly the basis of improving health care." The council also noted, "We have an obligation to protect the integrity of the medical profession."

SPONSORSHIP SOUGHT FOR IMMUNIZATION BILL

The Society hopes to introduce a bill to help promote preschool immunizations. In response to

Resolution 93-4, which directs the Society to pursue legislation requiring more stringent vaccinations, the board has approved draft language for a new immunization bill.

The bill would mandate the Advisory Health Board to publish a list of immunizations required of children attending any school, day care, or camp, or being treated at any public health clinic operated by the state. The Pennsylvania Academy of Pediatrics has indicated support for the Society's language, citing that it allows for flexibility to easily adapt Pennsylvania's requirements to federal guidelines.

The Society is now seeking sponsors for the bill; introduction is anticipated early in 1995.

PHILADELPHIA RESOLUTION SPARKS ACTION

Providers should know how they're being judged, Philadelphia physicians and others have said with increasing urgency.

In response to a resolution submitted by the Philadelphia County Medical Society, the board approved a series of recommendations which seek to require Pennsylvania's health insurance carriers to provide all physicians and subscribers with the parameters or guidelines the carrier uses to review patient treatments and hospitalizations.

The recommendations, developed after study by the Society's Council on Medical Economics, direct the Society to: support utilization review legislation, which addresses the release of guidelines upon request; draft a letter to the insurance commissioner requesting release of the guidelines; and continue to encourage the AMA to follow-up on their related policies.

The board also voted to support as a pilot the initiative of the Pennsylvania Chapter of the American Academy of Pediatrics to implement a resource based relative value scale (RBRVS) reimbursement system for those Pennsylvania Medical Assistance recipients between the ages of 0-21 who are enrolled in the Family Care Network, a primary care case management program. The RBRVS would only be applied to various evaluation and management codes, not all services.

SOCIETY TO PETITION STATE TO AMEND NEWBORN REGS

In response to a board-approved recommendation of the Interspecialty Section, the Society will petition the Pennsylvania Department of Health to amend its Physical Examination and Required Treatment of Newborn regulations.

The debate: Must a physician be in the delivery room to perform a complete physical examination on a newborn infant before it leaves the room? The section says no, citing that such a requirement is unnecessary and inconsistent with clinical guidelines endorsed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Board Reviews Reports on '93 House Actions

At this meeting prior to the October House of Delegates meeting, the board approved several reports in response to 1993 House action:

- *Resolution 93-9, Medicare Catastrophic Act of 1988*—Called for Society's AMA delegation to present a resolution to the AMA seeking an amendment to the law that would qualify patients for medically necessary nursing home care, even if they have declined hospitalization in an advance directive.† The Council on Education and Science reported that since the AMA's initial efforts on this issue did not result in any change, legislative action would be required to correct the situation.

- *Resolution 93-10, Budget Neutral Conversion to RBRVS*—Directed the Society to review the merits of litigation charging that the initial resource based relative value scale (RBRVS) conversion factor was improperly calculated, and to consider supporting the litigation. Society general counsel, after extensive monitoring of AMA activities and careful study of the issue, reported that such litigation is unlikely to be successful.

- *Resolution 93-20, Laboratory Studies as Screening Tools for Patients in Long-Term Care Facilities*—Called for the Society to work with the Department of Health (DOH) to adopt more appropriate requirements for laboratory screenings of patients in long-term care facilities.† The Council on Education and Science reported that DOH intends to revise the regulations and is willing to place a Society representative on the panel that reviews them.

- *Resolution 93-68, Medical Staff Self-Governance*—Called for an individual who personally or through an employer holds a contractual obligation with a hospital, its parent corporation, or any subsidiary, to be ineligible for membership on a hospital medical staff executive committee unless elected by the staff in its entirety or by a department in an open-nomination election.† The Governing Council of the Society's Hospital Medical Staff Section (HMSS) reported that the AMA adopted a similar resolution in December 1993, and through AMA efforts, "the intent of the resolution has been accomplished."

- *Resolution 93-71, Economic Credentialing*—Directed the Society to oppose economic credentialing as the sole or primary criterion for determining hospital medical staff privileges, and directed the Board of Trustees to report to the House of Delegates on the ramifications of economic credentialing for hospital medical staffs and the development of health care networks. The HMSS Governing Council reported that language reflecting this opposition has been added to the Society's "Model Medical Staff Bylaws." The council also outlined the possible negative effects of economic credentialing on health care delivery.

New resolutions

The October issue of the Society's *Executive Report* included summaries of 73 resolutions submitted for this year's annual meeting of the House of Delegates in Hershey.

Resolutions address: unification/deunification, state regulation of laboratories, care for the indigent, confidentiality, continuing medical education, physician review for medical staff, independent review of third-party payers, freedom of choice, antitrust and discrimination litigation, conflict of interest, public health, and reimbursement, among others.

Look for complete annual meeting coverage next month in PENNSYLVANIA MEDICINE.

† *1993 House of Delegates referred for further study.*

Electronic Claims Are First Step in Computerization

Eric L. Marr

Electronic claims submission (ECS) in the U.S. took hold in the early 1980s. Today, more than 20 percent of all medical claims—including an estimated 16 percent of all claims filed by physicians—are submitted electronically. This article explores some of the advantages to ECS.

By the end of next year, nearly all Pennsylvania physicians will be using—or on their way to using—electronic claims submission (ECS). About half of all physicians' offices file at least a portion of their claims via computer, and many file over 90 percent electronically. Even so, the percentage of electronic claims filed by doctors still lags well behind that of hospitals and pharmacists.

A recent survey conducted by Strategic Marketing and Research, Inc., discovered that, as expected, medical practices with computers in their offices are more likely to understand the ECS process and view it favorably. The survey also identified several reasons why some physicians had not filed claims electronically in the past. These reasons included: lack of interest, office too small, the belief that ECS causes too much work, and in some cases, lack of knowledge about ECS in general.

But as ECS gains popularity among physicians and their staffs, the benefits, ease of installation regardless of practice size, and wide range uses of electronic claims are becoming commonplace. More and more physicians are finding that the advantages of electronic claims outweigh the early uncertainties of the electronic process. Obviously, times are changing, and influences are at work that may spark almost total conversion from paper to electronic claims processing within the next 10 years...or less.

Mandated filing looms

Government mandates will be a significant factor in a push to encourage physicians to file claims electronically. As recognized in the September 1994 issue of *Medicare Report*, a quarterly newsletter published by Pennsylvania Blue Shield, ECS standards provide an electronic format that can be shared by insurance carriers for the purpose of electronic claims filing. According to the article, approximately 470 local formats will be replaced by a standard format like the National Standard Format (NSF).

The Health Care Financing Administration (HCFA) hopes to lessen the administrative costs associated with processing numerous paper billing forms by promoting electronic claims and the NSF. Although HCFA doesn't currently require Pennsylvania's electronic claims submissions to be NSF compliant, early 1995 has been targeted as the time frame to complete the transition.

Based on information from other carrier newsletters and bulletins, the NSF's uniform standards for submission of medical claims will be available in 22 states by January 1995. A full national implementation of these standards will eventually follow, dependent on the ability of the state to effectively accept and incorporate these changes.

H. Jerome Noel, secretary-treasurer of the Association for Electronic Health Care Transactions, and vice president of ClaimNet, a national electronic claims clearinghouse, says, "While initial mandates may apply only to group medical practices and clinics of a certain size, use of ECS by all physicians appears to be only a matter of time. It is imperative that physicians align themselves with organizations that have the ability to maintain NSF standards, as these standards are still evolving."

Gaining ground

Pennsylvania Blue Shield estimates that of all Pennsylvania physicians filing Medicare Part B claims, 76.7 percent do so electronically. The *Automated Medical Payments Directory* states that the percentage of claims processed electronically increased 30 percent from 807.8 million in 1992 to 1.05 billion in 1993. Patient services reimbursed through Medicare and

Mr. Marr is marketing manager, Physicians Practice Management, Indianapolis.

Medicaid account for the vast majority of electronic claims processing at present. HCFA says Medicare Part B annual claims volume for 1994 is projected to be 630 million, of which 70.9 percent will be processed electronically. The *Automated Medical Payments Directory* estimates that Medicaid's annual claim volume for 1993 reached 874 million claims, up 68 million from 1992.

Figures like this certainly suggest that the health care industry—payers and providers alike—is taking strides to do away with paper claims. Whether the move to electronic claims is due to carrier requirements or a desire to more effectively manage claims traffic, the benefits for making the move are substantial and very real.

Users recount ECS benefits

As office manager for a large, single-physician practice in Indiana, Pennsylvania, Lisa Gardner, of Thomas McCoy, MD, went from being "sort of iffy" about converting to electronic claims to a solid supporter. Changing from an earlier computer system was something she kept putting off. However, once making the commitment to go to electronic filing, the transition was "smooth and fast." Gardner says, "ECS is much quicker and simpler than paper filing and produces a much faster turnaround."

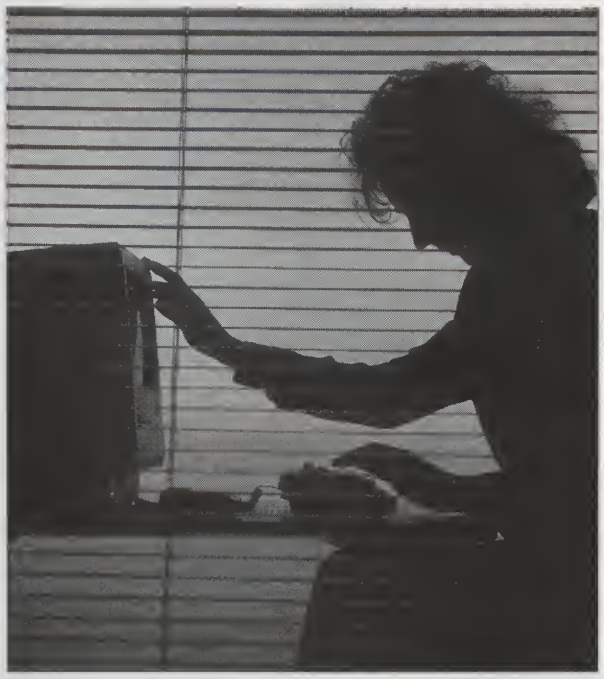
Conversion to electronic claims is becoming a simple decision for many physicians. In a recent survey of ClaimNet's Pennsylvania submitters, three benefits stood out as the motivating factors for area physicians deciding to go electronic.

First was the effect ECS would have in enhancing cash flow for the practice. With most major carriers guaranteeing at least a 14-day turn around on clean claims, practices would typically see an improvement in their cash flow.

Alleviation of time-consuming paperwork was the second most important reason to go with ECS. Considering the time saved in not having to manually complete claim forms, not having to stuff envelopes, and no longer having to apply stamps, it's easy to see why this rated so high on the list.

The third largest motivation was the convenience of electronic claims. Customers surveyed also noted that errors and glitches that trigger claims rejection are some of the biggest drawbacks of the present paper system. ECS innately brings improved accuracy to the process.

Cindy DelBianco, office manager for Paul DelBianco, MD, a Pittsburgh internist, has seen the practice go from start-



up in 1988 to a present patient roster of over 5,000. Her regret is that she didn't immediately begin using electronic claims processing when the office received carrier approval in 1988. "We save money on administrative costs, paper costs, turnaround and convenience," says DelBianco, who estimates annual economies in the thousands of dollars. The rapid growth of the practice, coupled with the opening of a second office, forestalled the conversion to electronic filing, but the volume of claims eventually became too much to handle manually.

Sandy Pierce is office manager for James Mayo, MD, who provides obstetric and gynecological services to more than 3,000 patients at Westmoreland Health Care for Women in Greensburg. After converting from paper record-keeping and claims processing in 1990, Pierce says, "The speedy turnaround time for payment of claims, reduced administrative work, time and savings of paper and postage, were major benefits." Faster processing of claims results in "better lab and support services for patients," says Pierce.

"The benefits of ECS are rapidly becoming a standard that most effectively managed practices depend on," says Cindy Cole, manager of National Accounts for Physicians Practice Management. "ECS will continue to grow regardless of the direction that health care reform may take."

Tip of the iceberg

As beneficial as electronic claims filing is, much greater benefits lie ahead for the computerized medical practice.

→

"ECS can be looked on as a kind of DNA building block for the electronic information world of tomorrow."

—H. Jerome Noel

Noel says, "ECS can be looked on as a kind of DNA building block for the electronic information world of tomorrow." It leads directly into the information super highway, where plugged-in physicians and their office managers will rely on electronics for a myriad of valuable functions.

He notes, "We are in the initial stages of testing outcomes management capabilities, primarily due to the capacity we have for transferring information electronically. One of the most topical and powerful concepts of electronic data movement is the ability to instantaneously collect encounter and outcomes data. The volume and importance of this data can be overwhelming, thus the need for effective software and powerful electronic capabilities."

Possible future functions of electronic data flow could include: eligibility status of the patient, benefits certification, remittance advice, automatic crediting of payments, movements of funds, the instant availability of patient data, and lab results. The electronic information highway will eventually connect physicians, carriers, and processors, and will allow instant access and delivery of important data. To the extent this information is used effectively, it may be a powerful tool that can produce significant benefits in the practice of medicine.

"Electronic reimbursement of claims is not far down the road. Carriers will soon be stepping up direct deposits to service providers with payment going right into physician's bank accounts," explains Cole.

Easy start-up

Three things are required to submit claims electronically: a personal computer, dependable ECS software, and a dependable modem. Obviously, more sophisticated software is available for additional functions in the office, but for ECS, this is all that is required.

Typically, a new installation takes a week to 10 days to start-up, depending on the commitment and computer experience of the person responsible for filing claims. If this person is familiar with computers, the process is extremely simple. For those with little or no computer experience, support or training from the electronic claims software developer is beneficial.

Completing the necessary paperwork for Medicare/Medicaid, assisting staff members with entering the practice's procedure codes, helping with entering the required provider numbers, or just talking someone through the process are services with which some developers help.

"Obviously, everyone has to use judgment as to when making the transition to ECS is doable, given their practice size and patient load," says Cole. "However, our customers tell us that once they decided to go with ECS, their ability to catch up accelerated dramatically, and that usually resulted in less pressure and a much more relaxed office environment. I also believe that having an ECS support person to contact when concerns arise is instrumental in alleviating the trepidation regarding ECS."

Beginning suggestions

To a physician or office manager still using paper claims, but ready to investigate ECS, a few suggestions:

- Check out the option of using a clearinghouse/processing service versus filing directly with insurance carriers. Review costs, upgrades, access to carriers (how many), and support.
- Work with your vendor. Vendors usually know the software and hardware best suited to meeting your needs—present and beyond—and can help you overcome computer inexperience. If you do not work directly with a vendor, there are consulting organizations that can make responsible, unbiased recommendations.
- Review the after-sales service support you can count on, both with regard to installation and online operations. Expect periodic service upgrades that will bring added features and benefits.
- Don't become enamored with a system with more bells and whistles than you need to meet reasonable present and future requirements.
- Be certain that your choice for software is NSF compliant.

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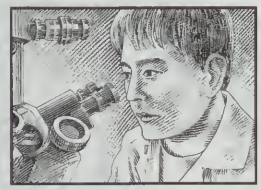

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Controlling Diabetes in Pennsylvania

Pennsylvania Department of Health
Diabetes Control Program

In a single day in Pennsylvania, 500,000 blood glucose tests are performed, and 250,000 insulin injections are given. There are also 554 new hospitalizations, 32 deaths, eight lower extremity amputations, four new cases of blindness, and two new cases of kidney failure due to diabetes. What is Pennsylvania doing to change these numbers?

The Division of Diabetes Translation of the Centers for Disease Control and Prevention (CDC) has established a conceptual framework to guide national and state-based efforts to reduce the burden of diabetes. In 1981, Pennsylvania was designated by the CDC as a Diabetes Control Program state.

The CDC-funded, state-based programs are expected to coordinate the following four activities:

1) defining the nature and extent of the diabetes problem within the state through surveillance of mortality and morbidity, and monitoring of health services and health outcomes;

2) developing new approaches to reduce the diabetes burden within evolving systems of care, such as health systems interventions that incorporate quality standards and protocols for diabetes care and education, community organization/mobilization and outreach efforts, and public education;

3) implementing specific program initiatives to ensure that accepted standards, policies, and protocols for diabetes are incorporated into the health care system; and

4) coordinating diabetes-related efforts of the public health system with private practitioners, payers, and other relevant governmental, voluntary, professional, and academic institutions.

The state's strategies

Pennsylvania uses three major strategies—collaboration, consultation, and education—to address the diabetes burden.

Collaboration—The state collaborates with medical and other professionals who provide advice and assistance in diabetes program planning and implementation. A special Pennsylvania Diabetes Task Force, appointed by the governor, provides this professional advice. Establishment of the Pennsylvania Recognition Program allows for quality community-based diabetes patient education.

Consultation—The state employs nine community-based diabetes nurse consultants who provide consultation and services to health care providers, institutions, agencies, and patients and their families in counties and districts of the commonwealth. These nurses also assist hospitals in developing outpatient education programs that meet National Standards for Diabetes Patient Education Programs, as developed by the National Diabetes Advisory Board.

Over the past 12 years, the nurses have provided resources, updates, or consults to over 73,000 health care providers or agencies; conducted 851 programs for school nurses and 31 programs for correctional facilities; and given educational materials or assistance to 85,645 individuals with diabetes.

Currently, 85 hospitals in Pennsylvania have been recognized by the Pennsylvania Department of Health as meeting the National Standards for Diabetes Patient Education. These hospitals have conducted 2,643 outpatient education programs reaching 19,874 people with diabetes.

Education—The state contracts with the Pennsylvania Diabetes Academy to develop educational materials for health care professionals and patients, disseminate current information on management and technological advances, and provide educational resources to practitioners, agencies, organizations, and consumers.

Other diabetes-related projects include:

- free foot and eye screenings, with assistance from the Pennsylvania Optometric Association, the Pennsylvania Podiatric Medical Association, and the Pennsylvania Diabetes Academy;

The information in this article was compiled by representatives of the commonwealth's Diabetes Control Program, with assistance from the Pennsylvania Diabetes Academy of the State Society's Educational and Scientific Trust.

Joslin Diabetes Center

Novo Nordisk DIABETES Care

Meeting the Glucose Challenge Upgrading Diabetes Therapy

. . . now that we know it matters

DEVELOPED IN COLLABORATION WITH THE JOSLIN DIABETES CENTER

SERVICE PROGRAMS FROM THE WORLDWIDE LEADER IN DIABETES CARE

UPGRADING DIABETES THERAPY IN NIDDM

What did the DCCT demonstrate?

Intensive diabetes therapy significantly reduced the risk of chronic complications of diabetes in patients with IDDM:

- Retinopathy was reduced by up to 76%
- Nephropathy was reduced by up to 56%
- Neuropathy was reduced by up to 60%

Intensive diabetes therapy was associated with weight gain as well as a significant increase in the frequency of severe hypoglycemic episodes. On the basis of these results, the investigators recommended that "most patients with IDDM be treated with closely monitored intensive regimens, with the goal of maintaining their glycemic status as close to the normal range as safely possible.[1]"

The American Diabetes Association extended this recommendation to patients with NIDDM:

> "It seems reasonable to recommend tight control in many patients with non-insulin-dependent disease because it is presumed that the mechanism by which glucose causes complications is the same in both forms of diabetes.[2]"

What do these findings mean to you?

Intensive diabetes therapy can require resources not readily available in many practices; however, the DCCT findings indicate that every incremental improvement you can make in your NIDDM patients' glycemic control can decrease their risk of subsequent diabetic complications. *Upgrading Glycemic Control in NIDDM: A Stepped-Care Approach* was designed to assist you in meeting the challenge of achieving and maintaining improved glycemic control in your patients with NIDDM.

How should you start to meet the Glucose Challenge?

A good way to begin is to familiarize yourself with the "Clinical Practice Recommendations for Diabetes Mellitus" found on this wallchart. This guideline indicates the minimum standards of continuing care for persons with diabetes that have been recommended by the American Diabetes Association.[3] You can photocopy the clinical practice recommendations and keep them with your patients' records to document that you have fulfilled these minimum standards of care for your NIDDM patients.

HOW TO USE THE STEPPED-CARE APPROACH FOR UPGRADING DIABETES THERAPY

STEP 1: Diet and Exercise

The first step in therapy for patients with newly-diagnosed NIDDM is dietary modification and an appropriate exercise plan. Initially, this form of therapy will be effective in approximately 17% of NIDDM patients.

Since the majority of NIDDM patients are overweight, a diet that provides 10-12 kcal per day per pound of desirable body weight can be prescribed. (For men, desirable body weight is 106 lb for the first 5 ft of height and 6 lb for each additional inch. For women, desirable body weight is 100 lb for the first 5 ft of height and 5 lb for each additional inch). There is no single "ADA" or diabetic diet; the diet regimen you prescribe should be individualized; emphasis should be placed on glucose and lipid goals.[4] Ideally, the patient should be educated about his or her new diet by a registered dietitian, unless you or other members of your office staff have the time and the expertise.

In those NIDDM patients for whom it is appropriate, an exercise regimen should be prescribed. A regimen that is not overly demanding is most likely to be followed by the patient.

After three months on a diet and exercise program, see where the patient stands on the Stepped-Care algorithm. If in the red zone (BG>200 mg/dL or HbA_{1c}>10%), the patient should be upgraded to Step 2 or referred to a specialized diabetes health care team. If the patient falls in the yellow zone (BG 140-200 mg/dL or HbA_{1c} 8-10%), you and your patient can decide (and document) whether to upgrade the therapy or to accept the potential risks of an additional three months of diet and exercise therapy under suboptimal glycemic control. If the patient falls in the green zone (BG<140 mg/dL or HbA_{1c} 6-8%), diet and exercise therapy should be continued.

STEP 2: Add Oral Agent

If, after a three-month trial of diet and exercise, you decide that the patient's therapy should be upgraded, the next step is to add an oral hypoglycemic agent (OHA) to the diet and exercise regimen.

You should explain to the patient the pharmacological characteristics of the OHA that you have chosen to prescribe, emphasizing the risk of hypoglycemia with these agents; and provide the patient with the capabilities for self monitoring of blood glucose (SMBG). Unless you and your office staff have the time and expertise, SMBG training is best provided by a diabetes educator.

After three months on a maximum safe dose of an OHA (plus diet and exercise), your patient should be reevaluated according to Step 2 of the Stepped-Care algorithm. When patients fall in the red zone, they should be upgraded to treatment with insulin. If they are in the yellow zone, you should discuss (and document) the risks of continuing the same therapy or upgrading to treatment with insulin. Patients who are in the green zone can be continued on OHA, diet, and exercise therapy for additional three-month periods until that therapy is no longer effective (which will happen eventually in most patients).

STEP 3: Change to Insulin

Patients with NIDDM who do not maintain adequate glycemic control with a program of diet, exercise, and OHA should be started on insulin without delay. Patients should be reminded that diet and exercise are still important components of their overall treatment plan.

Before initiating insulin therapy, the patient must receive instruction about insulin dosage, timing, injection technique, hyper- and hypoglycemia, and SMBG from a diabetes educator. In addition, the patient should be counseled in diet-insulin interactions by a registered dietitian. You should be accessible by telephone when you start patients on insulin therapy or when adjusting insulin doses.

Once-daily injection of insulin in the morning is considered suboptimal therapy; since this schedule is not physiologic, it is unlikely to provide adequate glycemic control, and it is likely to cause afternoon hypoglycemia and excessive weight gain. In contrast, once-daily bedtime insulin in conjunction with daytime OHA is gaining favor as a temporary transition between OHA and full-fledged insulin therapy.[5]

Twice-daily injection of premixed insulin (eg, 70% NPH/30% regular) provides a reasonable chance for achieving adequate (yellow zone) or even excellent (green zone) glycemic control. The replacement insulin dose is 0.25 units per pound of body weight per day, with two-thirds of the dose given before breakfast and one-third before supper. Obviously, the dose of insulin must be adjusted according to the patient's SMBG results as well as to the diet and exercise program.

Fortunately, hypoglycemia is less of a problem with insulin-treated NIDDM than it is with IDDM. This is because most patients with NIDDM are obese and insulin resistant; they have normal counterregulatory hormonal responses to a falling blood glucose; and they rarely miss a meal. Nonetheless, it is prudent to recommend regular SMBG to all insulin-taking patients at least twice daily.

STEP 4: Intensive Insulin Therapy

If two injections per day of a premixed or split/mixed insulin preparation do not bring the blood glucose or HbA_{1c} concentrations into an acceptable range, or if they achieve "better" control (yellow zone) when you and your patient want the "best" control (green zone), the optimal currently available choice is intensive insulin therapy. The two major forms of intensive insulin therapy are multiple daily injections (MDI) of insulin and insulin pump therapy.

There are several resources required for intensive insulin therapy. A diabetes nurse specialist must always be available for intensive training on hypoglycemia awareness, prevention, and treatment; as well as for SMBG and insulin adjustment training and counseling. You or a member of your staff must be available 24 hours a day by telephone (hotline). Professionals in behavioral medicine and exercise physiology should be available on an ongoing basis. Since these resources are beyond the scope of most medical practices, many physicians refer candidates for intensive insulin therapy to a specialized diabetes care team.

The Glucose Challenge: An Aid to Control

The Glucose Challenge is a program that uses the wallchart on the reverse side as a visual aid to help patients achieve glycemic control. To participate in the Glucose Challenge, simply select five patients who have poorly controlled blood sugar levels and whom you wish to motivate. Through use of the wallchart, you'll be able to visually identify each patient's goal, and readily discuss the patient's current status and progress.

If you follow the guidelines for Upgrading Diabetes Therapy with the Stepped-Care Approach, you and your patients will be able to meet the Glucose Challenge.

1. Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med.* 1993;329:977.
2. American Diabetes Association. Position statement: implications of the Diabetes Control and Complications Trial. *Diabetes Spectrum.* 1993;6:225.
3. American Diabetes Association. Clinical practice recommendations. Standards of medical care for patients with diabetes mellitus. *Diabetes Care.* 1994;17:616.
4. American Diabetes Association. Position statement: nutrition recommendations and principles for people with diabetes mellitus. *Diabetes Care.* 1994;17:519.
5. Riddle, M.C. Combined insulin and sulfonylurea therapy: a practical way to start insulin therapy for people with NIDDM. Therapy for people with NIDDM. *Clinical Diabetes.* 1994; 12:57.

Please photocopy and place in patient's chart

PATIENT NAME_____

CLINICAL PRACTICE RECOMMENDATIONS FOR DIABETES MELLITUS

This guideline indicates minimum standards of continuing care for stabilized patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care.

Indicate that a task was performed by initialing box. Shaded boxes are optional tasks.

VISIT	Initial	3 mo.	6 mo.	9 mo.	Annual	3 mo.	6 mo.	9 mo.	Annual
DATE									
PHYSICAL:									
Complete history and physical									
Height and weight									
Blood pressure									
Ophthalmoscopic exam									
Foot exam									
Interim history and physical									
LABORATORY:									
HbA_{1c}									
Random plasma glucose									
Lipid profile									
Urinalysis									
Urinary microalbumin									
Serum creatinine									
ECG									
OTHER:									
DOCUMENT GOALS & MANAGEMENT PLAN									
REFERRAL TO OPHTHALMOLOGIST									

Adapted from *Diabetes Care*, 1994; 17(6)616.

ICD-9 CODES:

250.—0 NIDDM, not stated as uncontrolled
250.—2 NIDDM, uncontrolled
250.—1 IDDM, not stated as uncontrolled
250.—3 IDDM, uncontrolled
250.— Indicates complication and type of diabetes

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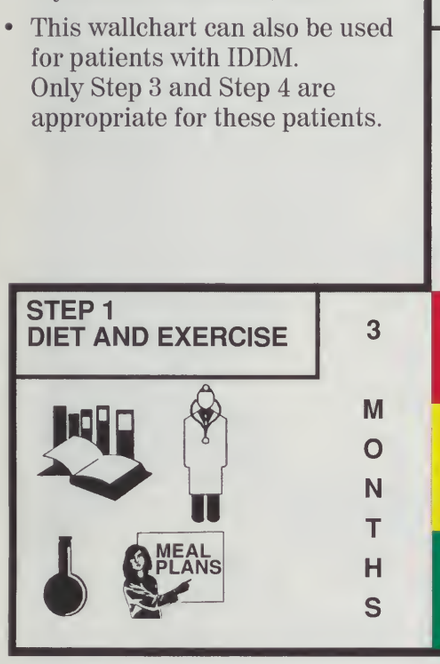
meeting THE GLUCOSE challenge

Upgrading Glycemic Control in NIDDM

A STEPPED-CARE APPROACH

The objective of the Glucose Challenge is to help patients lower their blood glucose and HbA_{1c} levels from an unacceptable (red) zone to the better (yellow) or best (green) zone in 6 months.

- Start by identifying patient's current treatment step.
- Use color key to determine glycemic control.
- Follow recommended action for identified level of control.
- Icons indicate resources you need (in addition to those from preceding steps) for upgrade; if you lack resources, refer.
- This wallchart can also be used for patients with IDDM. Only Step 3 and Step 4 are appropriate for these patients.



COLOR KEY

UNACCEPTABLE
BG >200 mg/dL; HbA_{1c} >10%

BETTER
BG 140–200 mg/dL; HbA_{1c} 8–10%

BEST
BG <140 mg/dL; HbA_{1c} 6–8%

RESOURCE KEY

- Physician — NAME ____ PHONE # ____
- Diabetes education — NAME ____ PHONE # ____
- Dietitian — NAME ____ PHONE # ____
- Blood-glucose monitoring
- Hotline Access
- Insulin
- Nurse/Educator — NAME ____ PHONE # ____
- Oral hypoglycemic agents
- Lab tests — PHONE # ____
- Psychological counseling — NAME ____ PHONE # ____

INSTRUCTIONS

- Select five patients who have blood glucose levels above 200 mg/dL or HbA_{1c} > 10%.
- Using the Stepped-Care diagram, discuss with each patient his/her treatment, and goals for blood glucose and HbA_{1c} levels.
- Write in the date, the current step, and the patient's blood glucose and/or HbA_{1c} values in the upper left red square.
- Ask the patient to select a one-word identifier in lieu of the patient's name or initials, and write it on the chart.
- Schedule follow-up visits for 3, 6, 9 and 12 months.
- Schedule the laboratory tests before the patient's office visit.
- At the follow-up visits, fill in the patient's data in the appropriate square.
- If the patient's blood glucose value or HbA_{1c} value has improved by at least one zone (ie, from the red to either the yellow or green) at the 3-month visit, and is maintained or advanced at the 6-month visit and subsequent visits, you and your patient are meeting the Glucose Challenge.

START ____ STEP ____ | 3 MO ____ STEP ____ | 6 MO ____ STEP ____ | 9 MO ____ STEP ____ | 12 MO ____ STEP ____

BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%
PERSONAL PATIENT IDENTIFIER	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%
	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%

START ____ STEP ____ | 3 MO ____ STEP ____ | 6 MO ____ STEP ____ | 9 MO ____ STEP ____ | 12 MO ____ STEP ____

BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%
PERSONAL PATIENT IDENTIFIER	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%
	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%

START ____ STEP ____ | 3 MO ____ STEP ____ | 6 MO ____ STEP ____ | 9 MO ____ STEP ____ | 12 MO ____ STEP ____

BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%	BG ____ >200 mg/dL HbA_{1c} ____ >10%
PERSONAL PATIENT IDENTIFIER	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%	BG ____ 140-200 mg/dL HbA_{1c} ____ 8-10%
	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%	BG ____ <140 mg/dL HbA_{1c} ____ 6-8%

For more information and additional copies of the Glucose Challenge wallchart, contact your Novo Nordisk Representative at 1-800-727-6500.

• a traineeship in diabetes care and the older patient, through the Pennsylvania College of Podiatric Medicine, to help podiatric students gain a clearer understanding of the diabetic manifestations and complications involving the foot; and

• a referral system to the Pennsylvania Association of the Blind's eye care program.

New initiatives include:

• a community mobilization program in Erie;

• development of the "Taking Control" education and behavior modification program at Hamilton Health Center in Harrisburg; and

• a program to identify and address barriers that impact patient outcomes in rural primary care settings.

Regional activities

In addition to the activities of the Diabetes Control Program outlined above, the counties and districts (see map at right) offer types of assistance to people with diabetes. Each county or district is assigned a diabetes nurse consultant, who oversees community activities and works with health professionals and patients.

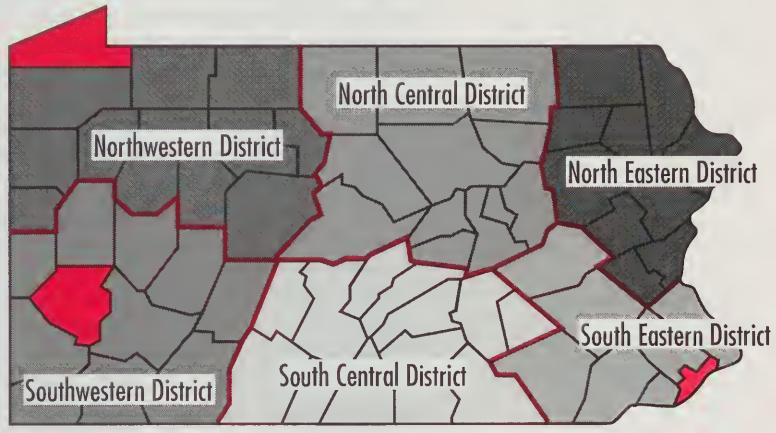
Allegheny County—In response to a need identified through a physician survey in Allegheny County, the county health department developed a diabetes education program for individuals who have neither the insurance nor financial means to attend a hospital-based program. The program is taught by the diabetes nurse consultant, with assistance from a public health nutritionist of the Chronic Disease Program. Participants are encouraged to make behavioral changes that will improve their diabetes control and prevent or delay complications.

The diabetes nurse consultant also provides updates and training on care of the patient with diabetes to staffs of nursing and personal care homes. Educational programs are a particular need in personal care homes because of limited access to professional staff development programs, and patient care is mainly provided by aides with minimal diabetes training.

In-service programs are conducted for teachers, school nurses, and other staff members at schools where there is a child with diabetes. These programs focus on management issues or handling emergency situations that may affect the student while at school.

As for Allegheny County hospitals, 13 have recognized outpatient diabetes education programs, and two others are in the process of setting up education programs that will meet national standards.

Pennsylvania Department of Health
Health Service Districts



Allegheny, Erie, and Philadelphia counties are independent of the districts.

Erie County—The diabetes nurse consultant in Erie provides education, resource, and support services to the county's 13 school districts, two prisons, and Senior Care Network. Hamot Medical Center and St. Vincent Medical Center both have state-recognized outpatient diabetes education programs which educated over 90 individuals with diabetes in the first six months of this year. Five other Erie County hospitals have inpatient education, support groups, and community services for their patients with diabetes.

The Erie County Diabetes Association is a local, independent agency that provides financial, emotional, and educational support for the diabetes community. As of July 1993, all diabetes efforts in the area are linked through the Erie County Diabetes Coalition. This initiative brings together over 60 health care providers, social service agencies, and individuals with diabetes to more efficiently and cost effectively meet the needs of the diabetes community. Through this group's efforts, over 17,000 "Diabetes Alert" brochures were distributed in Erie County.

Philadelphia County—Since 1990 the Philadelphia Department of Public Health has offered a free diabetes education program, "Staying Healthy with Diabetes," to its clients at seven district health centers. The program consists of a series of seven classes (plus graduation) and is scheduled at each health center between two and four times a year. Registered nurses teach the classes in conjunction with a diabetes nurse specialist. →

In May this year, a Spanish version of "Taking Control" was begun, using Kensington Hospital as its site. The Health Promotion Council's Latino Project Coordinator translated all materials into Spanish. Currently, classes are conducted in Spanish twice a year at District Health Center #6.

District Health Center #4 offers a unique diabetes education program for African Americans. Funded by the Pennsylvania Department of Health and administered by the Health Promotion Council of Southeastern Pennsylvania, "Taking Control" is a modified version of "Staying Healthy with Diabetes" that adds 15 minutes of exercise plus meal preparation to each class. Participants eat a healthy lunch together each week based on traditional ethnic foods and are given the recipes to take home.

The program includes a pre- and post-knowledge and attitude assessment, and follow-up for one year. Blood glucose, HbA1 c, cholesterol, weight, and blood pressure are monitored. Two registered dietitians from the Health Promotion Council teach the classes, held on Tuesdays and Saturdays.

Six Philadelphia hospitals have outpatient diabetes education programs that have been recognized by the Pennsylvania Department of Health for meeting the National Standards for Diabetes Education. Classes range in frequency from two programs a month to four programs a year. Three other hospitals are in the process of completing applications for recognition.

North Central District—The diabetes nurse consultant in North Central Pennsylvania provides assistance to hospitals interested in delivering programs or obtaining recognition for their outpatient diabetes education program. Two hospitals in the district have recognized programs, and one additional hospital is in the process of completing the recognition application.

Diabetes in-service programs are conducted for teachers, school nurses, and other school personnel in an attempt to provide a safe environment for the student with diabetes and to relieve the anxiety of the teaching staff. An annual newsletter is sent to all school nurses in the district to provide general and new information as it becomes available. Information is also included at camps and teen weekends sponsored by the American Diabetes Association.

Diabetes in-service programs, on the day-to-day management of diabetes and how to handle emergency situations, are provided to non-professional staffs of nursing homes, long-term care facilities, and group homes.

This district also employs a referral system, and assistance is provided to the Bureau of Blind and Visual Services in instruction and training of adaptive devices for diabetes care.

Northeastern District—This district's senior centers of the Area Agency on Aging provide patient education consultations and in-service to persons who have diabetes or who are caretakers. Assistance with diabetes education and resources is also provided to home health agencies, physicians' offices, long-term care facilities, and churches.

In-service education programs also help the nursing staff of the district's state correctional institutions to determine the needs of the population with diabetes at the facilities, and school district nursing supervisors and staff are working to improve the management and care of students with diabetes. The diabetes nurse consultant provides resources and educational materials to facilitate this process.

Nine hospitals in the Northeastern District have outpatient diabetes education programs recognized by the Pennsylvania Department of Health, and two others are in the process of completing recognition applications. Also, local assistance programs are used to help persons in need obtain diabetes services and educational resources.

The diabetes nurse consultant provided education, resources, and consultation to more than 5,000 individuals with diabetes, educators, institutions, and agencies during fiscal year 1993.

Northwestern District—Seven hospitals in Northwestern Pennsylvania have outpatient diabetes education programs recognized by the Pennsylvania Department of Health, and one more is currently in the process of completing the recognition application. Over 250 clients with diabetes were educated in these programs in 1993. The diabetes nurse consultant provides other hospitals with specific diabetes resources, references, and referral information on a regular basis.

The district's school nurses use the pamphlet, "Guidelines for the Student with Diabetes," as an individual care plan. Printed with assistance from the Western Pennsylvania Association of Diabetes Educators Chapter, the pamphlet is available to school districts in Western Pennsylvania.

Individuals with diabetes who need an eye examination, and who meet needs criteria, are helped through referrals to the

Pennsylvania Association for the Blind's diabetes eye care program. Individuals needing other diabetes-related services are directed to the appropriate community or state agency.

The district's diabetes nurse consultant teaches in-service education programs at community agencies, home health care agencies, schools, correctional institutions, and service organizations. In 1993, more than 1,350 individuals received assistance from the nurse.

South Central District—Collaborative efforts with health professionals to develop, implement, and present hospital-based outpatient diabetes education programs have resulted in the recognition of 12 hospitals in South Central Pennsylvania. Three additional hospitals are in the process of completing recognition applications, and 12 other institutions follow specific protocols for Veterans' Administration, rehabilitation, or smaller hospitals.

More than 1,000 people with diabetes have received education through these recognized programs. The district's diabetes nurse consultant provides in-service programs to other agencies and health professionals to meet their needs for education, referral, treatment, and management of clients with diabetes. These include hospitals, schools, school nurses, home health agencies, nursing homes, blind and visual services, the Office of Aging, correctional facilities, mental health/ mental retardation facilities, service organizations, and any group needing the resources provided through the Pennsylvania Diabetes Control Program. More than 2,000 individuals received assistance in 1993. In addition, the district has instituted a referral service for others afflicted with diabetes.

Southeastern District—After providing in-service programs for school nurses in seven counties of this district, a newsletter is sent to all school districts for dissemination. Information on Type I diabetes, coping strategies, family matters, peer pressure, research updates, and other school-related issues regarding diabetes is included, and when appropriate, the newsletter is shared with a student with diabetes and his or her family.

A nine-hour diabetes education program for African Americans has been conducted at district senior centers. Culturally sensitive educational materials are used, and ethnic foods are worked into meal plans. Participants have reported positive weight and blood pressure changes as a result of these programs.

Twenty-three hospitals in the Southeastern District conduct outpatient diabetes education programs recognized by the Pennsylvania Department of Health. Some address the needs of women with gestational diabetes, and many have meter loan programs, as well as individualized insulin and meal planning sessions. A newsletter keeps participants of these programs abreast of recognition issues, and provides updates on diabetes education and research. Over 830 clients with diabetes received education in these programs last year.

Also in the district, high school, college, and graduate students with diabetes-related education projects receive reference materials and community resource contacts, as well as creative and innovative ideas for project development.

Southwestern District—Like other districts, the goal in Southwestern Pennsylvania is to make the diabetes educator the primary community resource. Here, the diabetes nurse consultant offers consultative services to assist hospitals in developing quality outpatient diabetes education programs and support groups.

Eleven hospitals have recognized programs that meet national standards, four hospitals are working toward that goal, and six employ diabetes educators who follow the standards. Four physician and community-based programs use the standards.

Updates on diabetes education and care are provided to health professionals and the general public, and coalition building has begun in two counties. One of the identified needs was a program to provide diabetes supplies to financially needy individuals. Pharmaceutical suppliers cooperate by providing supplies for these individuals until other sources can be found. →

A Phone Call Away

Information about all of the activities listed in this article are only a phone call away. Please reference this article when calling.

Pennsylvania Diabetes Control Program: Louis Wolfel, Director—(717) 787-5876
Pennsylvania Diabetes Academy: Kathleen Dwyer, PhD, RD—(717) 558-7750
Allegheny County: Lynn Hollihan, RN—(412) 247-7814
Erie County: Theresa Byrd, RN, BSN, CDE—(814) 451-6704
Philadelphia County: Gail Thatcher, RN, MSN, CDE—(215) 685-1840
North Central District: Jean Mayes, RN C—(717) 327-3400
Northeastern District: Barbara Babcock, RN, CDE—(717) 826-2062
Northwestern District: Rebecca White, RN, CDE—(814) 332-6920
South Central District: Phuoc Tran, RN—(717) 787-8092
Southeastern District: Marian Pounder, RN C—(610) 378-4352
Southwestern District: Barbara Bodnar, RN, MSN, CDE—(412) 565-5107

At California University of Pennsylvania, located within the district, a biannual seminar on chronic disease, developed by the Diabetes Control Program, reaches student teachers through the session, "Managing a Student with Diabetes." This forum was one of the original pilot sites for the national program, "Foundation for the Future: Understanding the Student with Diabetes."

The American Association of Diabetes Educators-Western Pennsylvania Chapter, the American Diabetes Association, and the Juvenile Diabetes Foundation work in collaboration with the district program to develop materials, review literature, and sponsor health fairs.

Pennsylvania Diabetes Academy

In cooperation with the counties and regions, the Pennsylvania Diabetes Academy, created in 1984 as a nonprofit, educational corporation affiliated with Pennsylvania Medical Society's Educational and Scientific Trust, is charged with meeting the need for quality professional diabetes education in the commonwealth.

Through a contract with the Pennsylvania Department of Health Diabetes Control Program, the academy:

- develops professional and patient education materials;
- conducts a three-day workshop for diabetes educators throughout the state;
- disseminates to health care professionals and the public current information on the management and technological advances that affect therapeutic aspects of diabetes;
- provides educational resources to health care professionals, agencies, organizations, consumers, and lay groups; and
- disseminates diabetes research results in cooperation with the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Association.

In the past, PENNSYLVANIA MEDICINE has published "Standards of Medical Care for Patients with Diabetes Mellitus," highlighted individual efforts in diabetes care through Keystones of Public Health, and presented the results of the diabetes control and complications trial in "Upgrading Diabetes Therapy...Now That We Know It Matters."

To learn more about diabetes care, take the "Glucose Challenge" between pages 26 and 27.

...a promise to defend...

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Moderator: Michael S. Feldman, M.D.

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Understanding Generic Substitution

Jeff Greenawalt

Physicians are increasingly being called upon to allow substitution of generic equivalents when they prescribe. Managed care plans, state and federal government, health insurers, and others pressure physicians to allow generic substitution because they believe it will reduce cost; physicians just want to provide the best care for their patients.

This past summer, as the Pennsylvania Department of Public Welfare implemented its plan to only pay for generics, the issue surfaced once again. This review of how the system of generic substitution operates may help physicians understand the issues involved.

FDA approval

Like most states, Pennsylvania relies upon the Food and Drug Administration's (FDA's) list of acceptable generic substitutes. The key to understanding the system is understanding how the FDA creates this list, published in its *Approved Drug Products with Therapeutic Equivalence Evaluations,* commonly referred to as the "Orange Book." The introduction of the book explains creation of the list.

The FDA considers a generic drug to be the equivalent of the pioneer drug if the product is approved as safe and effective, is a pharmaceutical equivalent, is a bioequivalent, is adequately labeled, and is manufactured in compliance with applicable regulations. If all of these conditions are met, the FDA classifies the drug as *therapeutically equivalent,* awarding it an "A" rating. Obviously, some degree of extrapolation is required to determine therapeutic equivalence from these criteria.

Pharmaceutical equivalence occurs when two drugs have the same active ingredients, are of the same dosage form, and meet the same applicable standards (strength, purity, etc.). *Bioequivalence,* as defined by the FDA, means that the two products being compared display comparable bioavailability when studied under similar experimental conditions.

Bioequivalence forms the basis for an abbreviated new drug application (ANDA). Since the active ingredient in a medication was proven safe and effective when the pioneer drug was approved, an applicant seeking approval for a new brand of the same drug must only demonstrate bioequivalence. This greatly reduces the cost of the application and, at least in theory, contributes to the cost reductions experienced with generic products.

Bioequivalence studies are generally conducted with 12 to 24 normal male adults. Single doses of the test and reference drugs are administered, and blood or plasma levels are measured over time. If the rate of absorption differs by 20 percent or less, the FDA considers the medication bioequivalent.

Note, however, that the FDA generally requires an applicant to compute a two-sided test using a 90 percent confidence interval. Consequently, any product that had a mean response nearly 20 percent less or greater than the pioneer's mean response will probably fail this test. It is, therefore, not correct to state that the mean response for generic drugs is up to 20 percent different than pioneer products, when meeting the 90 percent confidence rule will likely make the variation much less.

Physician concerns/response

Concerns about this process were behind the creation of State Society Resolution 92-14: Information on Generic Drugs. The resolution called on the Society and the AMA to work with the FDA in providing physicians with specific data on the bioavailability and bioassay of generic drugs. The Society's Commission on Licensure and Practice of the Health Care Professions evaluated the resolution and concluded that the FDA's ANDA process does provide reasonable assurance of safety and efficacy of generic drugs. The commission reviewed information on the approval process and found that the actual variance between pioneer and generic medications is about 3.5 percent.

Satisfied with the FDA process, the commission focused its attention on the distribution of bioavailability data requested by the resolution. Its members noted that even with an ANDA, the amount of data produced far exceeds that which would be valuable to individual physicians.

The commission pointed out that for those physicians desiring access to this information on any generic drug, the FDA can provide a Summary of Basis of Approval, a synopsis of the bioequivalence review. To request a copy of this report, call (301) 443-6310

In addition, the commission noted that the U. S. Pharmacopoeia is incorporating *in vivo* bioavailability standards into its publications. Many Society members already subscribe to those publications.

The commission concluded that due to the quantity of data available on generic drugs and their general safety and efficacy, it is not practical, necessary, or cost effective to provide every physician with bioavailability and bioassay data on every generic drug.

Physicians appear generally satisfied with the effectiveness of most generic drugs. Occasionally, our members have reported some problems with generics. One must keep in mind that the FDA points out that even when it considers a generic therapeutically equivalent to a pioneer product, the generic may differ in shape, scoring configuration, packaging, excipients, expiration time, and some minor aspects of labeling. The FDA suggests that if a physician believes that these are important

considerations, the physician should specify a brand name in his or her prescription. This may become more difficult as many prescription payment programs insist on generic substitution as a cost-controlling measure.

State law

In Pennsylvania, the Generic Substitution law allows for a generic substitution if authorized by the prescriber. If a physician writes a prescription for a particular product and allows substitution, the pharmacist may substitute any generic rated "A" by the FDA. However, if the physician writes generically, the pharmacist may substitute any generic product he or she has in stock regardless of whether or not the FDA issued a determination of therapeutic equivalence by awarding an "A" rating to the product. This is a very important distinction since some problems noted by physicians may be the result of the use of a "B"-rated generic that may not perform in a manner that the physician expected.

For example, the FDA will only award an "A" rating to a substitute for a time-release medication that also uses a time-release formulation. A physician who writes for a brand of time-release medication should find that the patient received another time-release formulation. Conversely, the physician who writes generically could find that the patient received a medication without a time-release formulation.

The Pennsylvania Medical Society continues to believe that physicians must be allowed to make the best judgments for their patients free of interference from third parties. Unfortunately, others who finance the care may limit that choice.

Mr. Greenawalt is the Society's director of educational and scientific affairs.

Home Health Guidelines Reviewed

In response to a 1993 House of Delecates action, the Society's Commission on Licensure and Practice has reviewed federal guidelines and state regulations for home health care. The commission has recommended to the 1994 House that no changes are necessary to the current law.

In question was the time frame for reporting to physicians. Current law mandates physician oversight of home health care agency representatives (i.e., visiting nurses) for payment to the agency. After careful review, the commission concluded that current law clearly addresses the question: Physicians must review and acknowledge the patient's plan of treatment every 62 days.

Because the law is complicated in many areas, physicians should refer to the state regulations for clarification. Also, the AMA has published, "Guidelines for the Medical Management of the Home Care Patient." Call (800) AMA-3211 for information about the guidelines.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

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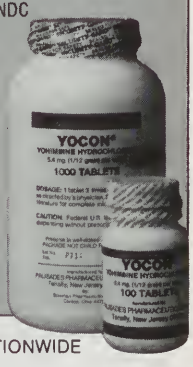
Rev. 1/85



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Outpatient Addiction Services Expand in Pittsburgh

Gwendolyn Schultz

Since the mid-1970s, Lee H. McCormick, MD, Pittsburgh, has been involved with the treatment of persons afflicted with chemical or alcohol addiction. Presently, he is the medical director of drug and alcohol recovery services, South Hills Health System; medical director of chemical abuse services, Braddock Medical Center; and associate medical director of the Center for Chemical Dependency Treatment, St. Francis Hospital.

Lee H. McCormick, MD, is a pioneer in the treatment of persons affected by drug or alcohol dependency—he worked in addiction medicine before it was a certified specialty. As Dr. McCormick describes it, he became involved in addiction medicine "by accident." He was asked to serve as the primary treatment physician in a clinical pilot drug and alcohol program through what is now the South Hills Health System.

When he began, he was unsure about the logistics of addiction and the treatment of these illnesses. But as he continued to help individuals, he understood the disease and the reasons his patients continued to use these substances. In 1986, the first year such certification was available, Dr. McCormick received his certification through the American Society of Addiction Medicine.

The stigma against addiction

Dr. McCormick defines an addicted person as, "someone who continues to use a substance although they know it is wrong and harmful to them." There has always been a stigma placed on alcoholics and drug abusers. Dr. McCormick thinks society views the disease of addiction differently than it does other diseases because the public views addicts as choosing to take these substances and harming themselves.

"People don't look at people with emphysema and asthma who smoke as bringing it on themselves. They don't look at diabetics who gain weight, eat anything they want, and end up in the hospital as bringing it on themselves. They don't look at cardiacs who won't lose weight, eat salt, and don't do the right things who end up in the hospital over and over again as bringing it on themselves. But, they think alcoholics and drug addicts bring it on themselves."

But, he says the stigma against addictive disorders is slowly fading because more people are recognizing addiction as a disease and not looking at it as a form of voluntary behavior or chosen habit.

Addiction—a public health snowball

Dr. McCormick says addiction and its effects are at the root of many other public health problems. Societal violence—including child abuse, spousal abuse, and homicide—AIDS, auto accidents, and infant mortality statistics many times can be traced back to addiction and the problems created from substance abuse. This is why more attention needs to be focused on treating addiction and expanding present programs.

"If you look at those problems, and look at how intimately connected they are to alcoholism and drug addiction, you could make some inroads in the treatment of addiction. You could reduce the public health costs of these other problems dramatically."

Dr. McCormick

The misconceptions of addiction

Although physicians are aware of drug and alcohol addiction, many say they

Ms. Schultz is assistant director of marketing and development for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

don't see more than a few cases in their own practices and medical settings. But Dr. McCormick and many researchers disagree. Studies and statistics show that addiction is widespread and does not affect only one socioeconomic area, one geographic area, or one profession.

Dr. McCormick explains, "The problem is the misconceptions that the public has are carried over into medical schools: that the alcoholic or the drug addict is the guy sitting in a doorway with his brown bag and wine, or the addict is the guy who is in the back alley 'shooting up.' They don't understand that a lot of alcoholics and addicts are working in Pittsburgh, Harrisburg, Philadelphia, and any city you name. They are going to work everyday, and while they may not be functioning well, they *are* functioning. These are the people that the medical students need to see, so that they get over that misconception of the derelict and the drug addict or the alcoholic."

Dr. McCormick says, "I think addiction is something that cuts across all lines, and although teaching of addiction has improved, it still does not get the attention that it deserves, considering its importance and prevalence."

Too little funding

The greatest problem in combating addiction is the lack of funding, according to Dr. McCormick: "There are enough treatment facilities, but the funding is grossly inadequate. It's even drying up." The result, he says, is the inability to treat patients *adequately*.

He adds that those in charge of delegating public health funding want to save money today. "They don't understand that sometimes you have to spend a little money today to be able to spend less tomorrow...to treat these patients to their full extent now, rather than spending more money in the future when they re-enter the program because they were not in stable recovery from their illness," he says. "We have to be able to provide enough funding to follow that individual as an outpatient for as long as necessary. This is where we are lacking."

Outpatient treatment—forging ahead

Dr. McCormick has been involved with addiction treatment at the South Hills Health System for almost 20 years, serving as the primary provider of addiction treatment for hundreds of individuals.

Traditionally, addiction treatment has been performed on an inpatient basis, with few services being rendered as outpatient. Currently, Dr. McCormick is in the process of changing that. Being involved with the South Hills Health System, the Braddock Medical Center, and the Center for Chemical Dependency Treatment at St. Francis Hospital in Pittsburgh, he has many resources and opportunities available to him. He and other physicians are trying to create a full-service outpatient addiction treatment *network*.

The goal of the network, he says, would be to "offer a number of locations and a number of [addiction treatment] providers so that we can be in the backyard of anyone who needs help." The network would link the services of six different treatment facilities: St. Francis-Central, St. Francis-New Castle, St. Francis-Main, South Hills Health System, Braddock Medical Center, and Charter Outpatient.

The project has been underway for approximately six months. Once the network is established, physicians providing chemical dependency treatment, nurses, therapists, and counselors will be available to patients at each of the centers.

Presently, Dr. McCormick is administering the progress of the network by developing appropriate protocols and procedures. He hopes to move traditionally inpatient services, such as detoxification treatment, to outpatient clinics; eventually, he wants to create an addiction treatment "manual" which will be the "outline and blueprint" for future outpatient treatment facilities and networks.

Physician involvement

Dr. McCormick feels physicians need to become involved with issues surrounding addictive disorders in two ways. First, they need to address addiction in their medical practices each day with each patient. Dr. McCormick emphasizes that in many addiction cases, the addict will not outrightly admit to having a problem and may also deny any addictive activity. It is up to the physician to spend time with each patient and get to the root of the problems in order to make the proper diagnosis, he says.

A member of the Pennsylvania Attorney General's Medical/Legal Advisory Board on Drug Abuse since 1989, and a board member of the Foundation for a Drug-Free Pennsylvania, Dr. McCormick also encourages physicians to be a strong voice in legislative activities so they may affect future changes in the medical environment. He concludes, "There are a number of things physicians need to do. First, they need to know their legislators, both Pennsylvania and federal; second, they need to communicate with them; and third, they need to stay with it." ⬡

"There are enough treatment facilities, but the funding is grossly inadequate. It's even drying up."

—Lee H. McCormick, MD

Society Venture Ever Growing

Maria T. Montesano
Assistant Managing Editor

The State Society has welcomed a staff clinical pharmacist and new services for physicians to its ever-growing Center for Professional Drug Education and Information.

In a first-of-its-kind venture in the U.S., the Pennsylvania Medical Society in 1993 joined with the Pennsylvania Department of Public Welfare to meet drug utilization review (DUR) requirements imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1990. Today, the Society's Center for Professional Drug Education and Information offers even bigger and better things for physicians, including consultation by a staff clinical pharmacist.

Brenda K. Trimmer joined the Society on September 1 as the center's clinical pharmacist. She received her B.S. in science with an emphasis in biology from Morehead State University in Kentucky and graduated cum laude with a B.S. in pharmacy from the Philadelphia College of Pharmacy and Science.

A Pennsylvania native, Trimmer has a varied background in hospital, community, and long-term care pharmacy. She recently spent five years in Georgia as a member of a multidiscipline consulting firm, advising long-term care administrators and nurses to assure compliance with state and federal regulations.

When she returned to Pennsylvania in 1993, Trimmer was a consultant pharmacist with Pharmacy Corporation of America, again working extensively with long-term care, including drug utilization evaluation and comprehensive drug regimen reviews. Trimmer, the recipient of a number of honors and awards for her pharmaceutical expertise, is a fellow of the American Society of Consultant Pharmacists.

As the center's clinical pharmacist, she is responsible to review patient profiles and analyze data, and for the educational arm of the retrospective DUR under contract with the Department of Public Welfare.

The center received its first set of physician profiles at the end of October. Trimmer explains that any intervention—which, she stresses, is strictly educational and *not* punitive—would include utilization comparison between peers and written information on drug classes.

"From there," she says, "if misuse is severe enough, the physician may be called to discuss utilization and answer any questions he or she might have." Further, if necessary, the center would conduct face-to-face interviews, which could be pharmacist-to-physician or physician-to-physician, depending on the situation. "And if there is a need to educate a number of physicians in one geographical area," Trimmer says, "the center will offer group sessions, which will provide CME credits."

But the center's job extends well beyond basic education. According to Trimmer, she and the center can help physicians by providing:

- information on medications, including dosage, side effects, and clinical applications;
- drug identification—if a patient has medication in a bottle, the center can identify over 45,000 prescription and over-the-counter drugs based on imprint of tablet/capsule;
- patient-specific dosing guidelines;
- information on international drugs;
- analysis of drug interactions for up to 15 drugs simultaneously and of drug-food interactions;
- patient information describing a specific injury, disease, or drug, customized for each patient and available in English, "easy-to-read" English, and Spanish; and
- wall charts and pocket cards comparing costs of drugs, such as the one on the opposite page.

Next year, the center will jointly sponsor with MSA/MEDNET two seminars—one in Philadelphia and one in Pittsburgh—on "Effective Prescribing for Minority Patients." A first program was held in Harrisburg in September. These programs seek to enhance physicians' understanding of the prescribing practices affecting physicians serving minority populations. CME credit will be provided.

Also, the center is working with the Pennsylvania Liquor Control Board to publish pamphlets and posters on drug-alcohol interactions, to be distributed largely through the commonwealth's State Stores.

Suggested Reading

Review these PENNSYLVANIA MEDICINE articles for more information:

- "Pennsylvania Takes Lead in Drug Education Venture" (July 1993): Explains the Society's role in the state's drug utilization review program and overviews how OBRA requirements will affect Pennsylvania physicians.
- "DUR Program Moving Ahead in Second Year" (October 1994): Provides an update of the state DUR program, including state as well as State Society efforts.

Also, the magazine has published three cost comparison charts in 1994: nonsteroidal anti-inflammatory drugs (February), quinolone antibiotics (April), and broad-spectrum antibiotics (June).

Professional DRUG EDUCATION & INFORMATION
Pennsylvania Medical Society

The center is still in development and interested in hearing what other projects would be helpful to physicians. Call (800) 228-7823 or (717) 558-7750 with your ideas, for further information, or to access the center's many services.

COMPARING CALCIUM CHANNEL BLOCKERS

Physicians across the state agree that they need an unbiased source of information on prescription drugs. Based on the results of a statewide survey, Pennsylvania physicians are especially interested in reliable drug cost information. In response, the State Society's Center for Professional Drug Education and Information has periodically published in PENNSYLVANIA MEDICINE cost information for medications in various drug classes. The fourth drug class in this series is calcium channel blockers.

Calcium channel blockers are most commonly prescribed for their antihypertensive effects; however, specific drugs may have indications for use in angina pectoris, arrhythmias, and subarachnoid hemorrhage. Physicians should base selection of a calcium channel blocker on indication, clinical experience, patient convenience, side effects, and cost.

The chart below presents the average wholesale price of a one-month regimen plus a $3.50 dispensing fee. While prices vary from pharmacy to pharmacy and region to region, this chart provides physicians with a means for making relative comparisons among commonly prescribed calcium channel blockers. The drugs are listed in alphabetical order by brand name.

For a free pocket card or wall chart version of this information on calcium channel blockers, call the Society's Center for Professional Drug Education and Information at (717) 558-7750 or (800) 228-7823. *NOTE: if you have previously requested other drug classes, you will receive this information automatically.*

The Center for Professional Drug Education and Information was established to assist in retrospective drug utilization review for Pennsylvania Medicaid prescriptions and to provide Pennsylvania physicians with an alternate, non-biased source of information on prescription medications. The Society is working with the Pennsylvania Department of Public Welfare, and Health Information Designs, Inc., on this program. Our goal is to help physicians make better prescribing decisions through education.

Calcium Channel Blockers—Cost of 30 Days of Therapy

BRAND NAME	GENERIC NAME	ADULT DOSING	QUANTITY	BRAND COST	GENERIC COST
Calan	Verapamil	40 mg TID	90	$32.25	$27.11
		80 mg TID	90	$44.86	$23.35
CalanSR		120 mg QD	30	$29.23	$29.23
		240 mg QD	30	$40.80	$37.61
Cardene	Nicardipine	20 mg TID	90	$38.76	NA
		30 mg TID	90	$59.57	NA
CardeneSR		30 mg BID	60	$40.22	NA
		45 mg BID	60	$61.82	NA
Cardizem	Diltiazem	30 mg QID	120	$53.76	$45.38
		60 mg QID	120	$82.26	$68.90
CardizemSR		60 mg BID	60	$49.66	$45.02
		120 mg BID	60	$72.28	$64.68
CardizemCD		120 mg QD	30	$29.15	$29.96
		240 mg QD	30	$52.30	$33.18
Dynacirc	Isradipine	2.5 mg BID	60	$34.03	NA
		5 mg BID	60	$48.25	NA
Norvasc	Amlodipine	2.5 mg QD	30	$37.51	NA
		10 mg QD	30	$62.34	NA
Plendil	Felodipine	5 mg QD	30	$29.56	NA
		10 mg QD	30	$50.32	NA
Procardia	Nifedipine	10 mg TID	90	$55.93	$42.60
		20 mg TID	90	$97.85	$79.91
ProcardiaXL		30 mg QD	30	$39.04	$28.73
		60 mg QD	30	$64.99	$47.15

Notes
Cost = Average wholesale price plus $3.50 dispensing fee. Dosage and duration may have to be adjusted for disease severity, age, and/or co-morbid conditions. NA = no generic available.

Source
1994 Red Book. Medical Economics Company, Oradell, New Jersey.

This comparative table was assembled by the Center for Professional Drug Education and Information of the Pennsylvania Medical Society and Health Information Designs, Inc. (HID)—a firm specializing in drug utilization review, based in Fairfax, Virginia—who is a partner in the Pennsylvania Medicaid Retrospective DUR program. *Copyright 1994, The Prescription Drug Education Project.*

Do You Speak "Medispeak?"

David Woods

While "Medispeak" has certainly been proven to have a place in medicine, it is a language that patients and their families may not understand or appreciate.

Every profession has its jargon, a word that derives from Middle English *gargoun*—twittering of birds. Among insiders, that twittering serves as a specialized and often useful "in" language; even though it's not the vocabulary of everyday speech, it has its place. The problem arises when legalese, journalese, or other forms of jargon are used in communicating with—or in the presence of—outsiders. Then, intentionally or not, it can become exclusionary or threatening. Moreover, where it is meant to impress, or even oppress, it can become a powerful and dangerous weapon.

This is especially true in medicine. While jargon isn't unique to medicine, "medispeak"—or as the *Oxford Companion to the English Language* (OCEL) dubs it, medi*cant*—certainly isn't new. The medieval physician Arnold of Villanova suggested that his thirteenth century colleagues mask their scientific limitations with lengthy Latinate locations.

Physician and novelist Michael Crichton calls this "obligatory obfuscation," noting, in an article in the *New England Journal of Medicine,* that this cannot be due to defensiveness since, "while articles in medical journals may often be stuffy, stodgy, weak and equivocal, dense, impenetrable, and forbidding, physician authors who are criticized in those same journals invariably respond in strong, brisk, and often stinging prose." Revealing that he is not immune to jargon himself, Crichton concludes that "medical obscurity may now serve an intragroup recognition function like a secret fraternal handshake."

Acknowledging that studies of surgeons have shown that jargon used during surgery actually improves the communication of factual information with clarity and brevity, the OCEL goes on to note that "ability to understand and use the jargon of a group is a badge of identification...It indicates that the user is conforming to the norms of the group, as well as accepting and understanding [its] basic ideas, principles, and practices."

So, while physicians readily understand that cephalalgia means headache and emesis means vomiting, patients might not; in fact, hearing those words might induce the very conditions they describe. Yet sometimes, jargon, when it consists of euphemism or obliqueness, can be a kindness to the patient: better to learn, for instance, that senility is "decreased propensity for cell replication" or that an alcoholic is suffering from "chronic hyperingestation of ethynol."

Of greater concern, I think, is the medical "we." Like the royal or the editorial we, it is designed to cloak communication in an aura of respectability and received wisdom...as in "We see a lot of that" or, worse, "How are we today?" The impersonal "emphysema in the corner bed"—the reference to the disease, as opposed to the person with the disease—is in the same league. The same holds true for referring to human beings as cases of this or that. And the "Hi, Mary, I'm *Doctor* Smith" isn't far behind.

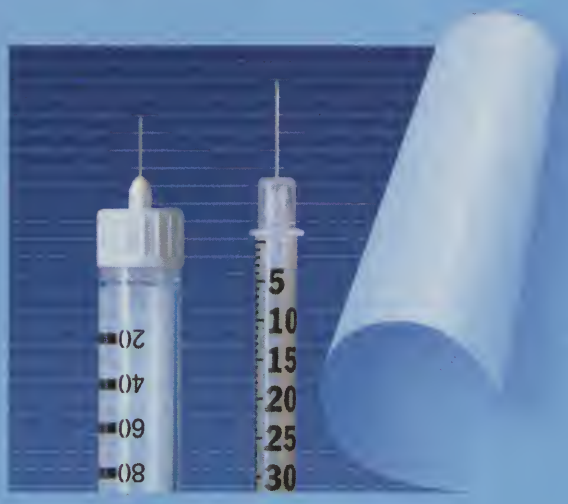
My colleague, John Gartland, MD, author of the recently published *Medical Writing and Communicating*, says that the characteristics important to good personal communicating are empathy, trust, honesty, and caring. Physicians, he says, should treat patients as they themselves would want to be treated. He points out that "the use of medical jargon, appearing hurried, or giving patients the sense of begrudging them adequate time to be heard...are the most commonly encountered barriers to effective communication between physicians and patients in face-to-face encounters."

The solution to all this? If you think you might be suffering from medispeak, the humorous answer is to seek out a psychosemanticist who will straighten out any linguistic ailments you might be suffering from.

More realistically, speak simply, personally, equitably, and kindly. It's a vital part of the therapeutic process. And *you'll* probably feel better, too. ⬡

Mr. Woods, former editor and publisher of the* Canadian Medical Association Journal, *is president of Healthcare Media International, Inc., Philadelphia, and a frequent commentator on health care issues.

Which insulin needle would you choose?



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702-94 September 1994

Sick Care to Total Care: Vertical Integration

Except for the decision you made to practice medicine, the decisions you make when faced with the question of whether or not to sell your practice probably will be the biggest of your career. *Your State Society offers a wealth of information on this topic through its new subsidiary, the PennMed Member Services Company (PMSCO). For more information, call (717) 558-7750.*

Vertical integration has been sweeping the commonwealth. One trend is for the managed care plan to purchase a hospital or hospital group and a number of physician practices, thus placing the insurance company, hospital, and doctors into a single network. Most large hospital systems are buying medical practices and suddenly, smaller hospitals—those not expected to be players—are also looking into buying practices.

Know what you want

Before you start negotiating, determine your wants, needs, and goals, and develop a strategy to get what you want. Think long and hard about the entire situation. You may not want to sell at all. Look at the alternatives to selling—especially any integration opportunities that allow you to retain some control of your practice.

A good consultant and lawyer can help you determine your goals, including whether you actually want to sell. Don't inadvertently trade off all of your bargaining chips for nothing or for the things that will not matter in the long run.

Make sure that, if you join, you will be able to practice medicine the way you want to, or at least in a way that is tolerable to you. Make sure you will see the patients you want to see and practice in the area that is best for you. Find out what amount of control you will have in your office, what changes will be made to your lifestyle, and what your administrative responsibilities will be.

If two organizations have made you offers, study them carefully. One may be offering you a lot of money and asking you to vertically integrate into a network in which people who are not doctors will be telling you what to do, while the other may be offering you less money but a "partnership," in which you will be making decisions.

Be aware that if the price being offered for your practice is, in all honesty, unrealistic, the only way that the buyer will realize the expected rate of return is to lower your salary, if not now, then later. In short order, your employer may determine that you are simply too costly a provider, or you may find that your new business cannot support itself because it has paid out too much money and/or it has too much debt. The last thing you want to do is join a network that is bound to go belly-up.

Beware of promises

Beware of blue-sky promises that are made by negotiators who, unbeknownst to you, have no authority to keep those promises.

Some negotiators will make any promises that they need to make in order to get you to sell your practice. Consider that putting up a building—which at least one large area buyer is promising—is probably going to cost a lot more than it will take to buy your practice. If that promise is made, how is it going to be kept and over what time frame?

If you are relying on a promise made to you, be sure that the promise is reduced to writing in the contract. Further, make sure that you set a firm time frame in which vital promises must be kept, establish financial penalties to trigger if they are not kept, and make sure you can get out of the deal, if necessary.

Setting a time limit is important. You may be trapped in a bad situation and be able to get out, but if you have been in the network too long, all your former patients will have found a new doctor, and all your current patients will belong to the network. If you leave, where will you get a patient base? Financial penalties work because you can evoke the penalty and use the money you receive to accomplish what was promised.

The Health Care Group

Understand that things will change

Understand that, once you sell your practice, you become someone else's employee, and your rights and obligations will be established in your contract, on which you may have no vote. Before signing the contract, be sure that you can live with it.

There will be changes in the way you practice. For instance, to increase revenues, your new employer may want you to work 50 hours a week, as you did before, but now devote all your time to patient care and none to administration.

You will have to live or die by the decisions made by someone else. Be sure that the entity you are joining has a professional manager. If a hospital runs your practice like a hospital, it may be run into bankruptcy.

If the entity you join has multiple management layers, your patients could suffer. In a managed care environment, if you get only one fee regardless of what you do, your variable cost patients—the sicker people—may get the short shrift because of administrative overhead, rather than the care they need.

Make sure there is a real administrative infrastructure. You might be very unhappy if you cannot affect changes you deem necessary simply because there is no one in the organization to whom you can point and say, "It's your job to fix this."

Always take a closer look

Of course, these changes may be acceptable to you, especially if what you really want or need is a large sum of money. If you sell, particularly after a bidding war, you will get cashed out immediately when the money is good.

But also be aware that if you sell your practice and agree to receive an annual salary of, for example, $130,000, your payment may be in terms of $106,000 guaranteed plus up to another $24,000 if you meet or exceed certain performance criteria.

The contributing author, Sandra E.D. McGraw, JD, MBA, is a lawyer and consultant with The Health Care Group and Health Care Law Associates, Plymouth Meeting.

Hahnemann University

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NOVEMBER 1994

November 16th
Asthma: Management Strategies
William Busse, M.D.
Professor of Medicine
University of Wisconsin
School of Medicine
Madison, WI

November 23rd
No Grand Rounds—Holiday

November 30th
Kidney Stone Disease
Douglas M. Landwehr, M.D., Ph.D.
Associate Professor of Medicine
Director, Division of Nephrology
and Hypertension
Allegheny General Hospital
Pittsburgh, PA

DECEMBER 1994

December 7th
Steroid-Induced Osteoporosis
Paul Katz, M.D.
Professor of Medicine, Microbiology, and Immunology
Chief, Division of Rheumatology, Immunology, and Allergy
Georgetown University School of Medicine
Washington, DC

December 14th
Cardiac Auscultation
Leonard S. Dreifus, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Daniel Mason, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Gerald Scharf, D.O.
Professor of Clinical Medicine
Division of Cardiovascular Diseases
Hahnemann University

John J. Ross, R.C.P.T
Research Assistant Professor
Division of Cardiovascular Diseases
Hahnemann University

December 21st
Metabolic Bone Disease - Osteodystrophies and Osteoporosis
Harmut Malluche, M.D.
Professor of Internal Medicine
Chief, Division of Nephrology, Bone and Mineral Metabolism
University of Kentucky
Lexington, KY

December 28th
No Grand Rounds—Holiday

JANUARY 1995

January 4th
Urinary Tract Infections
Donald Kaye, M.D.
Chair, Department of Medicine
Medical College of Pennsylvania and
Hahnemann University School of Medicine

January 11th
Antibiotic Resistance
Robert C. Moellering, Jr., M.D.
Shields Warren-Mallinckrodt
Professor of Medical Research
Harvard Medical School
Physician-in-Chief
New England Deaconess Hospital
Boston, MA

January 18th
Aspirin and Warfarin Combined Therapy-Multicenter U.K. Trials
Thomas W. Meade, D.M., F.R.C.P.
Director, Medical Research Council
MRC Epidemiology and Medical Care Unit
Wolfson Insitute of Preventive Medicine
The Medical College of
St. Bartholomew's Hospital
London, England

Prevention and Treatment of Abnormalities of Thrombosis Cardiovascular Disease
Yale Nemerson, M.D.
Goodhart Professor of Medicine and Biochemistry
Chief, Division of Thrombosis Research, Mt. Sinai Medical Center
New York, NY

January 25th
Complications of Drug Therapy in the Elderly
Michael F. Michelis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital
New York, NY

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

NOVEMBER 16, 1994
Asthma
Guest Lecturer:
William Busse, M.D.

DECEMBER 14, 1994
Cardiac Diagnostic Techniques for the Generalist Physician
Lecturers:
Leonard Dreifus, M.D., Daniel Mason, M.D., Gerald Scharf, D.O., John Ross R.C.P.T

JANUARY 18, 1995
Prevention and Treatment of Abnormalities of Thrombosis in Cardiovascular Disease
Guest Lecturers:
Thomas W. Meade, D.M., F.R.C.P. and Yale Nemerson, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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OBRA '93 EXTENDS SELF-REFERRAL RULES

Federal legislation that will take effect January 1, 1995, called OBRA '93, extends the current prohibition against physician self-referral of Medicare and Medicaid patients—now applicable only to clinical laboratories—to a wide range of other ancillary facilities owned by physicians, including:

- physical therapy services;
- occupational therapy services;
- radiology or other diagnostic services;
- the furnishing of durable medical equipment;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The prohibition to these additional services will be effective for referrals made after December 31, 1994. Exceptions in such areas as in-office ancillary services, prepaid plans, publicly traded entities, bona fide employment relationships, and other arrangements are clarified in the new law.

Susan Weber, JD, the Society's assistant general counsel, says, "We have received a number of calls from members and are helping to guide them as this deadline approaches." She adds, "Physicians should be careful to comply with the requirements of federal safe harbor regulations and Stark amendments in reviewing medically related investments."

For detailed information about OBRA '93, call (800) 228-7823 or (717) 558-7750, extension 490.

JOINT COMMISSION RECEIVES CLIA '88 DEEMED STATUS

The Health Care Financing Administration (HCFA) has announced that clinical laboratories accredited by the Joint Commission on Accreditation of Healthcare Organizations will be "deemed" to meet the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88).

Beginning January 1, 1995, the joint commission will conduct surveys for CLIA certification in both freestanding labs, as well as labs affiliated with hospitals and other health care organizations. Since CLIA regulations require that surveys be conducted every two years, labs affiliated with a health care organization will not be surveyed at the same time the organization is surveyed. However, they will be surveyed during the organization's full survey under the functional portions of the manual—such as leadership and improving organizational performance—as would other departments or services within the organization.

Also, according to the commission, labs that are part of one organization can be surveyed at the same time, requiring only one survey application and one fee.

For more information, call the joint commission at (708) 916-5783.

MEDICARE NEWS

PROVIDER INQUIRY NETWORK EXPANDING SERVICES

Pennsylvania Blue Shield has announced expansion of the Medicare Provider Inquiry Network to include electronic bulletin board and mail services. The new services are being implemented to increase the provider's "electronic advantage" and reduce the time and money they spend conducting Medicare business, Blue Shield says.

New capabilities include electronic filing of claim review requests, requests for general information and copies of payment vouchers, and address changes, as well as electronic RSVPs to Medicare Electronic Services and Medicare Professional Services provider seminars.

Providers may also continue to check the status of their claims and review Medicare fees, limiting charges, and Medicare policy through the network. All services are free of charge to Medicare participating providers via an 800 telephone number.

Current network users will automatically receive access to the new services; others will need to sign up for it. Direct questions about the network to Medicare Electronic Services at (717) 763,6722; press option 1.

ANSWERS OFFERED TO QUESTIONS ON NEW COVERAGE

Coverage of oral chemotherapeutic agents by Medicare, effective January 1, 1994, has raised a number of questions among physicians. To answer these questions, The Travelers, Durable Medical Equipment Regional Carrier (DMERC) for Region A, offers the following:

- Completed Certificates of Medical Necessity should be forwarded to the supplier, not HCFA or the DMERC unless specifically requested. The supplier is required to submit the completed certificate along with a completed HCFA 1500 form to the DMERC for specific items as outlined in the Supplier Manual.
- Physician-owned pharmacies are precluded by law from working through Medicaid and Medicare. Physician-owned pharmacies are not permitted to dispense prescriptions for oral chemotherapeutic drugs covered by the Medicare program.
- Nolvadex (Tamoxifen) tablets are not covered because there is no equivalent injectable form of the drug. Each of the four covered oral chemotherapeutic drugs has both an oral form and an equivalent injectable form.
- The limiting charge does not apply to oral chemotherapeutic drugs. The five percent non-participating physician differential does not apply to such oral chemotherapeutic drugs.

Direct other questions to The Travelers at (717) 735-9445.

AHCPR FUNDING PRIMARY CARE STUDY

A study of physicians who provide primary care in a managed care setting will examine whether their type of training affects resource utilization, medical outcomes, and costs. The $580,000 study is supported by the U.S. Public Health Service's Agency for Health Care Policy and Research (AHCPR) and Bureau of Health Professions, Health Resources and Services Administration.

The prospective study will compare differences in resource utilization, quality of care, and total costs during a one-year period for adult patients of family practitioners, general internists, and subspecialty internists providing primary care in a group model health maintenance organization (HMO).

Quality of care will be compared for five common chronic conditions: diabetes, hypertension, asthma, low back pain, and depression.

NEWSMAKERS

Delynne J. Myers, MD, assistant professor, University of Pittsburgh School of Medicine, and director of outpatient service, Division of Hematology and Bone Marrow Transplantation, has received the Leo H. Criep, MD, Excellence in Patient Care Award from the Pittsburgh Cancer Institute.

Gordon L. Kauffman Jr., MD, professor of surgery and cellular and molecular physiology, Penn State's Milton S. Hershey Medical Center, was named vice chair, Department of Surgery.

Jeffrey B. Wetstone, MD, program director, Williamsport Hospital and Medical Center Family Practice Residency Program, was appointed to the Healthcare Task Force of the Rural Development Counsel of the Commonwealth of Pennsylvania.

Dr. Park

Sang B. Park, MD, chairman, thoracic and cardiovascular surgery, St. Francis Medical Center, Pittsburgh, was elected to the board of directors of two St. Francis Health System affiliate corporations—St. Francis Health Care Services and St. Francis Diversified Corporation.

The American Academy of Ophthalmology has announced the following as 1994 Senior Honor Award recipients: **Gary C. Brown, MD**; **George W. Blankenship, MD**; **William E. Benson, MD**; **Peter J. Savino, MD**; **Marlene R. Moster, MD**; and **Donelson R. Manley, MD**. The award recognizes individuals who have made a significant contribution to ophthalmology through presentations at the academy's annual meeting and for service on academy committees.

Medical College Hospitals, Elkins Park Campus, has appointed **James T. Reinprecht, MD**, program director and liaison for the Medical College of Pennsylvania Internal Medicine Residency Program.

R. Michael Buckley, MD, chief of infectious diseases, Pennsylvania Hospital, Philadelphia, has been named associate director of clinical programs, Division of Infectious Diseases, Jefferson Medical College of Thomas Jefferson University, Philadelphia.

The Graduate Hospital, Philadelphia, has appointed **Scot A. Fisher, DO**, chair, Department of Radiation Oncology.

Michael W. Bowman, MD, an orthopedic surgeon from Pittsburgh, has authored a chapter, "Compression Neuropathies of the Foot and Ankle" in a recent publication, *Current Practice of Foot and Ankle Surgery, Volume II*. Dr. Bowman has also been named an associate editor of *Foot and Ankle International* and a reviewer for the *Journal of the American Academy of Orthopaedic Surgeons*.

Jonas T. Johnson, MD, an otolaryngologist-head and neck surgeon, is a receipient of the Distinguished Service Award from the American Academy of Otolaryngology-Head and Neck Surgery, for his long-term unrenumerated contributions to the academy.

Monongahela Valley Hospital has named **Nirmal D. Kotwal, MD,** director of laboratories, and **Dennis J. Mateya, MD**, medical director of the physical, occupational, and speech therapy departments.

Allegheny Valley Hospital, Natrona Heights, has elected **Michael D. Miller, MD**, chair, Department of Surgery.

Stuart G. Tauberg, MD, a cardiologist, was elected a fellow of the American College of Physicians.

Michael E. Thase, MD, medical director of the Mood Disorders Module, University of Pittsburgh Medical Center's Western Psychiatric Institute and Clinic, presented an analysis of the undertreatment of depression at the August annual meeting of the American Psychological Association.

Burton Singerman, MD, Upper St. Clair, has been named director of psychiatry, Center for Psychiatric Medicine, St. Francis Medical Center, Pittsburgh.

Alberto J. Larrieu, MD, cardiothoracic surgeon, Albert Einstein Medical Center, Philadelphia, participated in a charitable mission to Guadalajara, Mexico, implanting pacemakers in indigent patients. Dr. Larrieu also led a group of Mexican cardiologists as an instructor in pacemaker implantation.

John H. Glick, MD, director, University of Pennsylvania Cancer Center, Philadelphia, was appointed president elect of the American Society of Clinical Oncology.

Albert J. Stunkard, MD, emeritus professor of psychiatry, University of Pennsylvania Medical Center, Philadelphia, has received the American Psychiatric Association's Distinguished Service Award.

University of Pittsburgh Medical Center has appointed **Jorge Rakela, MD,** chief of transplantation medicine, director of hematology in the Division of Gastroenterology and Hematology, and professor of medicine.

Jeff Stanley, MD, emergency physician, Hospital of the University of Pennsylvania, Philadelphia, appeared on National Public Radio's "Morning Edition." Dr. Stanley discussed violence in America.

Herbert C. Mansmann Jr., MD, professor of pediatrics and associate professor of medicine, Jefferson Medical College of Thomas Jefferson University, Philadelphia, was honored by the American Lung Association of Delaware and Chester counties for his efforts in creating "Camp Superstuff" for the area's American Lung Association affiliates.

Dr. Lannutti

In *Newsmakers* of the September 1994 issue of PENNSYLVANIA MEDICINE (page 43), a picture of Leonard H. Finkelstein, DO, was inadvertedly used with information regarding Pat A. Lannutti, DO.

Dr. Lannutti—who is affiliated with the Philadelphia College of Osteopathic Medicine, and who has received the 1994 Christian R. and Mary A. Lindback Foundation Award—is pictured above.

FEASIBILITY OF DOCTOR-OWNED HMO UNDER STUDY

Private practice physicians throughout Pennsylvania have contributed more than $250,000 to fund a study that will determine whether or not a doctor-owned and operated health maintenance organization (HMO), called Pennsylvania Physician Healthcare Plan, Inc. (PPHP), is feasible in the state.

According to Gary Brown, MD, president of PPHP and an ophthalmologist based in Wyndmoor, the feasibility study began in October and will last for 14 weeks. The study will examine legal, financial, and marketing areas for PPHP, as well as poll physicians throughout the state as to whether they would support the establishment of such an organization.

The study will be performed by The Garvey Group, a Merrick, New York-based health care consulting firm, which has assisted physicians in Connecticut, Oklahoma, and New Jersey to organize their own statewide HMOs.

Exec quoted in *Modern Healthcare*

In related news, State Society Executive Vice President Roger F. Mecum expressed support for physician-owned networks in the August 29 edition of *Modern Healthcare.*

The article outlines a number of attempts in the northeast to form physician-owned networks, including PPHP, and explains, "Such new physician-controlled organizations are forming in response to worries that insurance entities rather than medical professionals are controlling medical care decisions."

Mecum emphasized that point to reporter Karen Pallarito, saying, "Our serious concern is that larger and larger insurance conglomerates are gobbling various pieces of the delivery system." He was also quoted at the end of the article, advising physicians "to try to get a little bigger."

Thomas Gabuzda, MD, president of the Philadelphia County Medical Society; John J. Nevulis, MD, vice president of PPHP; and Fred Palace, MD, president of the Medical Society of New Jersey, were also interviewed for the article.

COUNTY NEWS

MERCER COUNTY SPONSORS CONGRESSIONAL DEBATE

More than 80 people attended the first-ever congressional debate sponsored by the Mercer County Medical Society, held on September 14 in Sharon. At separate ends of the podium were Philip English (R) and William Leavens (D), both vying for the 21st District seat vacated by gubernatorial candidate Tom Ridge.

The health care debate turned into more of a discussion, with both candidates agreeing on a number of major points. Neither would:

- entrust their medical and psychological history to the U.S. government or any other organization that may want such records, as envisioned by the Clinton and Gephardt plans;
- support employer mandates for providing health insurance;
- support a single-payer system;
- support sanctions against physicians, as detailed in the Clinton and Gephardt plans; or
- support taxing health benefits.

Instead, they both favor a plan that would gradually reform health care. Both believe the U.S. has the best health care in the world, agreeing that some changes are needed, but not a complete overhaul.

More specifically, Leavens, former executive director of the Shenango Valley Chamber of Commerce, supports a plan that would create but not mandate health alliances, while English, a former Erie city controller, supports a plan that would make it easier for health care agencies to compete.

The one concept on which they did disagree is the best way to reduce health care costs. Leavens favors managed competition, but English says managed competition has not been proven to reduce costs and, instead, favors working to improve the current system.

Joseph A. Giordano, MD, vice president of the county society, moderated the health care debate, the first of its kind between the two candidates.

ALLIANCE NEWS

DONATION HELPS GEORGIA YOUTH AFTER SUMMER FLOODS

The Pennsylvania Medical Society Alliance (PMSA), through its Emergency Assistance Fund, donated $1,000 to the Georgia Medical Association Flood Relief Fund following floods resulting from Tropical Storm Alberto this summer.

Since the Red Cross met basic community needs, the Alliance's contribution focused on the needs of children: The funds supported the "Take Charge" project, a free mental assessment and support session for children regarding their reaction to the flood.

More than 100 Dougherty County (Georgia) children received packets of school supplies at "Take Charge," a free mental assessment and support session offered after the summer floods. The Pennsylvania Medical Society Alliance donated $1,000 to support the program.

According to Mary Linda Cotten, president of the Dougherty County (Georgia) Alliance, the money was used for school supplies, assembled and distributed to the more than 100 children who attended the "Take Charge" program. Additional packets of supplies were donated to the public school system.

In a note to PMSA, Cotten says, "I want to thank you for the financial support that the Pennsylvania Medical Society Alliance gave us to follow through with this project. Distributing school supplies at this mental assessment program met many needs of the children."

PMSA—the first alliance in the nation to establish an Emergency Assistance Fund to help people in areas hit by natural disasters—has been recognized by the AMA Alliance "for its concern and caring of physicians and their families and its fellowman." The fund, established in 1989 following Hurricane Hugo, has donated more than $13,000 to areas hit by natural disasters.

NEW CANCER AGENTS UNDER STUDY

Shadyside Hospital, Pittsburgh, and a consortium of nine other hospitals in three states have received approximately $1 million from the National Cancer Institute to evaluate the effectiveness of a group of new cancer agents. "Clinical trials" will determine which patients should receive such drugs or combination of drugs to combat a variety of cancers.

Investigators in the consortium are currently looking at the drug topotecan to determine its effect on lymphomas, and they will soon begin testing the impact of 9-amino-camptothecin on breast cancer. Both are part of a new class of anti-cancer drugs that may help inhibit tumor growth.

All of the hospitals in the consortium are linked by a computer system, which describes, step by step, the procedures investigators need to follow while conducting the trial. The grant will last for four years.

HMSS NEWS

CONFERENCE FOCUSING ON HEALTH CARE TRENDS

The American Medical Association is hosting the Fifth Annual *Interactions* Medical Staff Leadership Conference, January 13-15, 1995, in San Antonio, Texas. This year's theme is, "Physician Empowerment and Teamwork in a Changing Environment."

Discussion will focus on emerging trends in health care delivery—such as physician/hospital relationships, economic competition, physician autonomy, resource allocation, and regulatory constraints—and how best to manage them. Special emphasis will also be placed on developing and refining strategic planning, team building, and communication skills.

For more information or to register, call the AMA at (800) 621-8335.

CALL FOR PROPOSALS

PROGRAM WORKING TO IMPROVE ACCESS TO CARE

The Robert Wood Johnson Foundation has issued a call for proposals for a second round of planning grants for the $14 million "Reach Out" program. The program is a national effort to mobilize private physicians to improve access to care for medically underserved Americans.

In August, planning grants were awarded to 22 private physicians' groups in 21 communities throughout the U.S. to develop new approaches for delivering medical care to people who currently have difficulty obtaining it. Those grantees received development awards up to $100,000, and based on progress made during the first year, they will then be eligible to receive three-year implementation grants averaging $200,000.

The second round will include up to 28 additional physician-initiated partnerships. A workshop for interested applicants will be held on January 20, 1995, with an application deadline of *March 14, 1995.* Recipients of the second round of planning grants will be announced on August 1, 1995.

For more information about the grant program, or to request application materials, call the Reach Out National Program Office at (401) 453-5120.

Clinical Scholars Program

The foundation has also issued a call for applications for its 1995 Clinical Scholars Program, which is designed to allow young physicians committed to clinical medicine to acquire new skills and training in the non-biological sciences important to medical care systems.

The program offers two years of graduate-level study and research as part of a university-based, post-residency training program, and is open to U.S. citizens training in any of the medical/surgical fields, including psychiatry, pediatrics, obstetrics/gynecology, and family medicine.

For more information about the grant program, or to request application materials, call the Clinical Scholars Program Office at (609) 243-5919. *Deadline for application: March 1, 1995.*

MCP PROGRAM ARCHIVING WOMEN IN MEDICINE

The M. Louise Carpenter Gloeckner, MD, Summer Research Fellowship Award Committee of the Archives and Special Collections on Women in Medicine, the Medical College of Pennsylvania (MCP), Philadelphia, is accepting applications for summer 1995 research using materials in the archives and special collections.

The archives and special collections are the most comprehensive collection of materials in North American on women physicians. The archives house the business and academic records of MCP since its founding in 1850, and the special collections contain personal papers of women physicians; the records of women's medical organizations, schools, associations, and hospitals; and a collection of historic photographs.

One or two grants of up to $1,500 each for four to six weeks of research in the archives will be made to applicants selected by the award committee. One grant is reserved for medical students, the second for all other eligible applicants.

For an application and complete description of the fellowship, write to MCP at 3300 Henry Avenue, Philadelphia, PA 19129. *Deadline for completed applications is February 17, 1995.*

Next month in
PENNSYLVANIA MEDICINE
Annual Meeting Coverage

NEW MEMBERS

ADAMS

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ALLEGHENY

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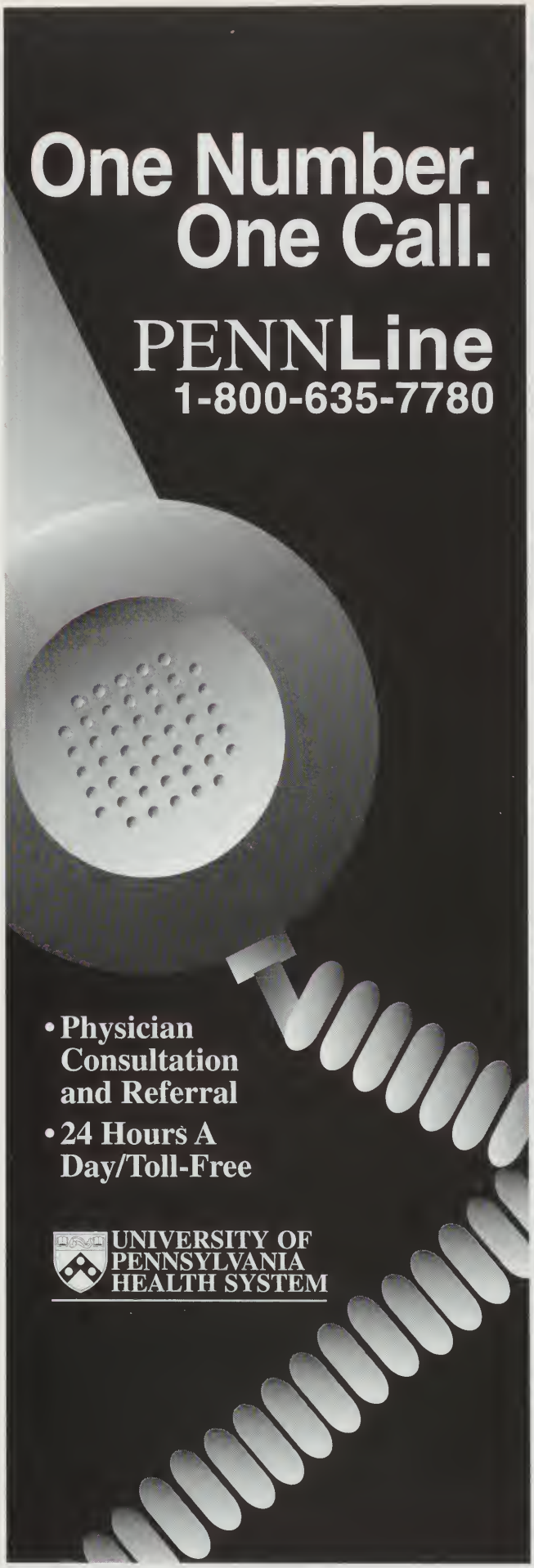

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Pennsylvania PRO Wins New Contract

I find it hard to believe that it's already well over two years since my article about the "possible" changes in store for the peer review organization (PRO) program. One of the major changes discussed in that article was the announcement by the Health Care Financing Administration (HCFA) of the proposed creation of Clinical Data Abstraction Centers (CDACs). Plans called for five CDACs which would use the new Uniform Clinical Data Set (UCDS) to abstract cases for physician review. The intent of the UCDS was to achieve greater uniformity in the screening of records from state to state.

Well, a lot has changed during the past two years. HCFA has decided to scrap the UCDS, not only because it was so detailed that it was not worth the extensive amount of time it took to abstract a record, but mainly because it was mostly intended as a tool for individual case review, which is gradually being phased out.

A new abstraction system, called the Medicare Quality Indicator System (MQIS), is designed to develop disease-specific quality indicators that will be used to profile providers' patterns of care. The intent is to design a methodology for the CDACs to collect data that is consistent with the new direction of the PRO program, the Health Care Quality Improvement Program (HCQIP).

Another change was in the number of CDACs—from the five originally proposed, to two. Both will be located in the east, within driving distance of HCFA's Central Office in Baltimore.

Not long after HCFA announced its intention to create CDACs, the Keystone Peer Review Organization (KePRO) formed a joint venture with DynCorp, Inc.—which had significant experience with government contracts—for the purpose of bidding on a CDAC contract. KePRO owns 45 percent of the joint venture corporation, named Dyn/KePRO.

HCFA issued a request for proposals on July 19, 1993, for the two CDACs, and Dyn/KePRO submitted proposals for both contracts on September 24, 1993. Almost a year later, on August 26, 1994, we learned that Dyn/KePRO was successful in its bid for what is referred to as the Central Zone Contract and includes 24 states and territories. This new five-year contract was effective on September 1, 1994, with an implementation date set for January 1, 1995.

KePRO is very pleased with this opportunity because it keeps at least one physicians' organization closely involved in the medical record collection/abstraction process, and we are one of only two original organizations in a brand new program.

Although it will be a challenge, this new contract will allow us to be innovative, as we proved we could be several years ago when we implemented intervening care and ambulatory surgery review—both of which were pioneered by KePRO.

The author, Donald E. Harrop, MD, is president of the Keystone Peer Review Organization.

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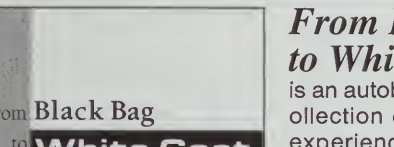

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The Asthma Crisis

Richard L. Green, MD

Caught up in the frenetic scramble for position in the managed care revolution, physicians can easily understand how a second, more subtle skirmish could have been overlooked. Tactical maneuvering has been intense in what I call "The Battle for the Asthma Patient."

The asthma patient has been around for some time. Even Maimonides cared for a few. It seems, however, that the medical profession is finally recognizing their existence, or that they have chosen now to come out of the closet. For years a battle has raged over the proprietary subspecialty rights to treatment of the asthmatic. Pulmonologists have felt that the lung, and all the diseases therein, belong to them. Besides, being internists, the inpatient care of the asthmatic crisis fell into their hands and onto their pulmonary intensive care units.

The allergist, on the other hand, felt that asthma is basically a hypersensitivity disease and could be dealt with through avoidance of allergic triggers, pharmacotherapy, and immunotherapy. And, of course, the generalists—represented by the family practitioner, internist, and pediatrician—feel that they do just fine, thank you, in controlling their patients with twitchy airways.

What has catapulted the asthmatic into sudden visibility is the "Asthma Crisis." It seems that the prevalence of asthma is on the rise. The number of people who have asthma has increased 60 percent between 1979 and 1989, representing all ages, races, and sex groups. Ten to 12 million Americans, or four percent of the population, suffer from this disease, and an estimated 3.9 million children under the age of 18 comprise this group.

Asthma accounts for 10 million missed school days and 200,000 hospitalizations each year. Even more disturbing is that the number of asthma deaths has increased since 1979 to nearly 5,000 a year. The asthma death rate is three times greater among African Americans than among Caucasians. Acknowledging the crisis, the National Heart, Lung, and Blood Institute (NHLBI) issued its expert panel's recommendations for the "Diagnosis and Management of Asthma"(see box in left margain).

And thus began anew the frenzied scramble for the asthma patient turf. Hospitals reasoned that if there were so many asthma patients out there, then it would make sense to establish "asthma centers" within their corridors. Pulmonologists have finally recognized that allergy contributes to their patients' wheezing, and have incorporated skin testing into their evaluations of the asthma patient and established their own "asthma and lung centers." And the allergist, not to be outdone, has included the word asthma in his or her corporate title, i.e., "Asthma and Allergy Clinic."

The upshot of all this chessboard-like maneuvering should be better care for the asthmatic. This heightened visibility should enable us all to diagnose earlier and more accurately. Care should be more accessible to the asthma patient because of more resources being devoted to them. And care should be better if NHLBI recommendations are followed.

So, who are the rightful purveyors of care to the asthma patient in the managed care environment? Who are the true descendants of Maimonides? I propose that we all are—the generalist and the specialist—and that the net result will be better care for the asthmatic, with reduced morbidity and mortality.

The generalist can acquire the skills of pharmacotherapy; the pulmonologist is expert in medical management of the mild, moderate, and severe asthmatic. And, because allergy plays such a prominent role in so many patients with asthma, the allergist can identify environmental triggers through allergy skin testing, draw up a program of environmental avoidance, initiate drug therapy, and initiate immunotherapy if indicated.

Hyposensitization, or immunotherapy, possesses the unique ability to make our patients' airways less allergic to the airborne allergens to which they are sensitive. In 1994 there now exist good, double-blind control studies that prove the efficacy of immunotherapy in patients allergic to tree, grass, and ragweed pollens, house dust mites, molds, and cat dander.

While the practice of medicine in the future will certainly be different than today, the outlook is bright for the asthma patient who can look forward to many breakthroughs in our understanding of the genetics and pathophysiology of his or her disease and to dramatic new therapies.

NHLBI Recommendations

These guidelines, developed by the National Heart, Lung, and Blood Institute, suggest the following for physicians treating the asthma patient:

1) recognize the role of inflammation in asthma and use mast cell stabilizing or corticosteroid inhalers daily and regularly to prevent attacks;

2) use bronchodilator inhalers on an as-needed basis only, and not every day all the time, because there is some evidence that the increased death rate is due to abuse of inhaled sympathomimetic drugs;

3) relegate theophylline to a back-up position rather than a first-line drug because of its high potential for cardiovascular and central nervous system side effects;

4) educate patients in the use of peak flow meters to quantitatively assess their airway disease;

5) use spacers for those who cannot properly use their metered dose inhalers;

6) prepare patients with crisis plans so that they know how to react to worsening airway compromise and may initiate the use of oral corticosteroids if indicated; and

7) educate the patient in the pathophysiology of the disease and in the environmental factors that can trigger exacerbations.

Dr. Green is an allergist with the Allergy and Asthma Associates of Pittsburgh.

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The following assumptions are based on a physician age 45; earning between $140-250,000 per year; retiring at age 65; annual investment growth of 10%; and a 20 year payout (8%) at retirement.

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3. $7,500 less is invested for 20 years. Assuming 10% annual return, your retirement fund is reduced by $429,000– cutting retirement security by $34,000 every year.
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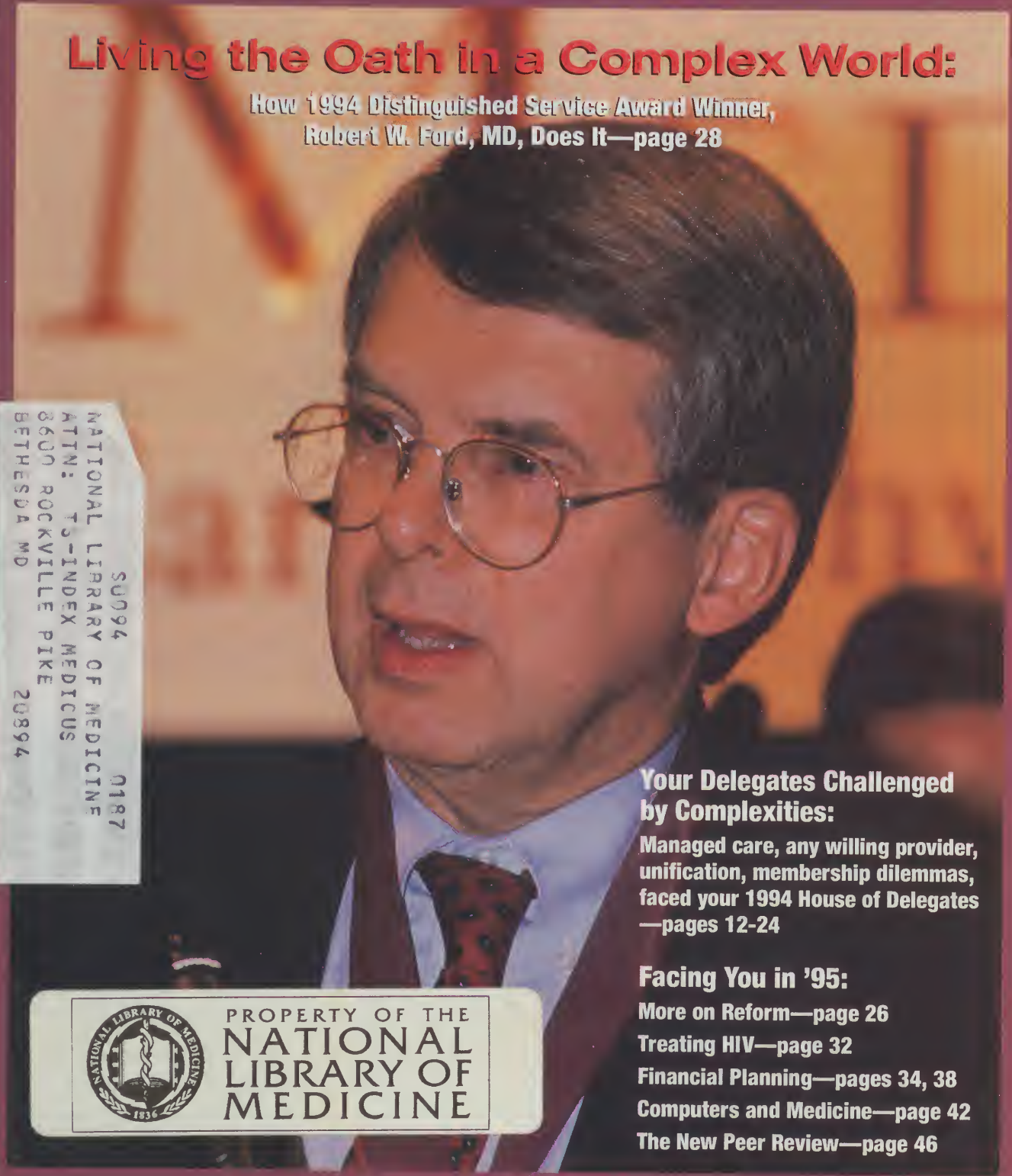
DECEMBER 1994

Living the Oath in a Complex World:

How 1994 Distinguished Service Award Winner, Robert W. Ford, MD, Does It—page 28



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Your Delegates Challenged by Complexities:

Managed care, any willing provider, unification, membership dilemmas, faced your 1994 House of Delegates —pages 12-24

Facing You in '95:

More on Reform—page 26
Treating HIV—page 32
Financial Planning—pages 34, 38
Computers and Medicine—page 42
The New Peer Review—page 46

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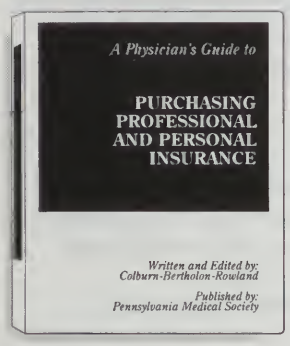

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Cover photo by Carl S. Socolow, Camp Hill

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THE EDUCATIONAL & SCIENTIFIC TRUST
of the Pennsylvania Medical Society

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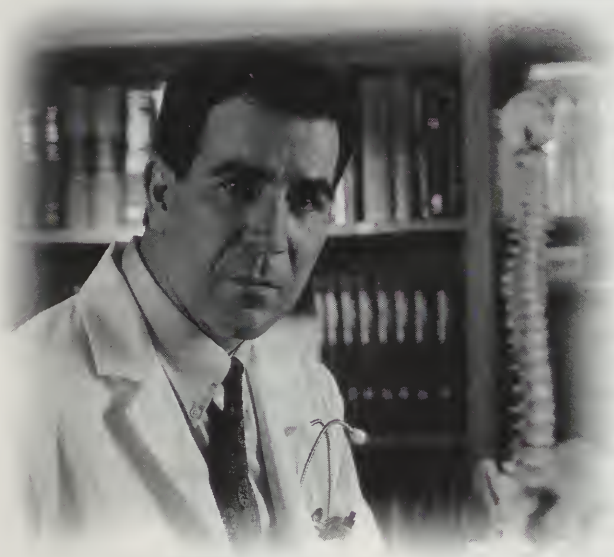

are lucky to have a resource like PMSLIC. I know. Early in my career I practiced in the Midwest. I saw colleagues get burned by a company promising the same medical liability protection for less money. I was pretty young, but luckily I didn't go with them. Unfortunately, my best friend, Phil, did. When his carrier went under, it looked as though a lot of good people would go down with it. Phil just got out by the skin of his teeth. A couple of our friends weren't so lucky. When I came to Pennsylvania, I checked out all my options. Know what? No company can match PMSLIC's record, or offer the same value-added services. Through the years, we've all heard many new carriers guarantee us big savings. But I can't see the value of saving a few dollars in the short run, if it means risking my future. Hey, if you don't believe me, give Phil a call."

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IRRC REJECTS WORKERS' COMP REGS, SEEKING REVISIONS: The Independent Regulatory Review Commission (IRRC) on November 29 rejected proposed regulations implementing Pennsylvania's new workers' compensation law. Among the commission's concerns: 1) time of payment for medical bills in cases where determination of medical necessity has been made, but the insurer is challenging; and 2) limitations on the list of designated health care providers. The Department of Labor and Industry had 10 days to revise the bill for IRRC process and approval; otherwise, the regs move back into the legislative process. At press time, no decision was made on department action. Prior to IRRC's decision, the Senate Labor and Industry Committee recommended disapproval of the regs, and the House Committee on Labor Relations declined to address the issue.

LIMITED LIABILITY BILL OFFERS NEW OPTION FOR PHYSICIANS: Senate Bill 1059, passed by the legislature in November, allows physicians to use a "limited liability company" as an alternative to the more traditional partnership or professional corporation. Such a company offers the principal advantage of a corporation—limited liability for the owners—coupled with the flexibility and tax advantages of a partnership. The State Society strongly supports the bill, which provides another organizational option for some physicians. Included in the bill are Society amendments requiring that only physicians may own limited liability companies that provide medical care. Specifically, the professional ownership requirements that apply to professional corporations also apply equally to limited liability companies. The governor is expected to sign the bill.

LAWSUIT, CONFUSION SEND HIO BACK TO THE DRAWING BOARD: The Commonwealth of Pennsylvania said it would revise bid specifications on its request for proposals for the HealthChoices health insurance organization (HIO), which was to have taken effect the first of this month. Proposals had been received from 12 companies, and a decision by the Department of Public Welfare had been anticipated as early as August. However, a suit filed in Commonwealth Court by advocates for Medical Assistance recipients and two coalitions of hospitals threatened to block the program. State officials said the bid specifications were being revised in light of a proposed settlement of the lawsuit. The HIO would affect about 650,000 low-income patients in Southeastern Pennsylvania.

ALABAMA COURT RULING ECHOES PENNSYLVANIA OPINION: A U.S. Circuit Court of Appeals ruled in November that the Alabama Medical Assistance Program must pay Medicare copayments and deductibles for the elderly poor who are eligible for both programs. In doing so, the court adopted in its entirety the opinion issued by the U.S. Third Circuit Court of Appeals in the suit filed against Pennsylvania Department of Public Welfare (DPW) Secretary Karen Snider by the State Society and James R. Regan, MD. A third appeal is pending in Virginia. DPW reportedly has been waiting for results in the other cases before deciding whether to seek U.S. Supreme Court review of the *Snider* decision. DPW has until approximately the end of the year to file such a petition. Meanwhile, the State Society has applied for a court order that would outline what DPW must do to comply with the Third Circuit Court's decision.

MEDICARE CUTS WOULD BE DEVASTATING, AMA SAYS: News reports on November 23 quoted leaders of organized medicine who testified against proposed Medicare cuts. AMA Executive Vice President James S. Todd, MD, reportedly testified that if Medicare cuts are made for health reform or deficit reduction, "the result in either case would be the devastation of Medicare as we and our patients know it." In related news, Medicare premiums for patients will increase to $46.10 a month on January 1.

DYN/KEPRO MARKS OFFICIAL START OF BUSINESS: Dyn/KePRO—a new joint venture between KePRO and DynCorp—held ribbon-cutting ceremonies on November 30 in York to mark its official start of business. The organization will serve as one of the first clinical data abstraction centers in the country under new HCFA rules.

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Lessons in Humility

John W. Mills, MD
Medical Editor

"Our delegates dealt squarely with the issues—something that contrasts sharply with the election campaigns going on outside our hall."

In the eyes of this ex-officio member—your Ninth District trustee—this year's annual meeting of the House of Delegates was perceptibly smoother than in the past, and without angry confrontation. I would like to think that all of the attendees were cognizant of the last few paragraphs of my October editorial. However, it's more likely that the temporary demise of national health system reform gave us all a much-needed respite, which helped the delegates to be more cohesive as a medical society and more ready to deal with the future. This is to be lauded, for only as a unit will we be able to progress successfully through the maze leading to the twenty-first century.

I do want to congratulate our speaker and vice speaker on a notable and difficult job expertly handled.

A highlight for me as an ob/gyn was the presentation of our Distinguished Service Award to Robert W. Ford, MD, of Allison Park. I think Bob typifies the meaning of a "real doctor"—serving others. That's really what we all do, but in Bob's case he does it in a missionary sense. Without taking away any laureates of previous recipients of the award—they have all been outstanding in their endeavors—I believe this is the first time that our award winner has been recognized for health care ministry to a Third World nation.

A different sort of award winner seemed fitting, in this different sort of annual meeting. There is no comparison between this smooth, well-ordered meeting and the political campaigns of the recent past. Whether or not to stay unified with the AMA was our biggest debate, and while there were strong positions on both sides of the issue, the debate was orderly, albeit passionate at times, and even eloquent.

The House's action to study the issue for another year may be called by some a "cop-out," but it is also a democratic process, which we know takes time. Some will argue that we have little time—I guess I'm in that group. The hemorrhage of membership from the Pennsylvania Medical Society *is* a serious issue with which your board and Council on Membership struggle daily, and while progress has been made, mandatory membership in the triune is an impediment.

Many felt that breaking our mandatory tie with the AMA was tantamount to rejecting the AMA outright as the profession's national "spokes unit," while others worried that the message we would send to Pennsylvanians in general would show lack of unity in our cause. Unfortunately, such perceptions have little to do with the actual mandatory membership rule. It might make a lot more sense for the AMA to consider unity to be 50 percent or more members from within any state. After all, plurality is not an unusual way to consider this.

Overall, our delegates dealt squarely with the issues—something that contrasts sharply with the election campaigns going on outside our hall. I think it's fair to say that voters have been turned off to politicians in general by the very stuff that the campaigns have fostered—mistruths. Witness our president stumping the country, ballyhooing statistics that are not and could not be results of his presidency in office less than two years. The national issues, like the ones before our delegates, are serious ones which should be given thoughtful public debate.

Now we've had another flip-flop, but of considerably more depth—control of the House and Senate by the GOP. Senator Robert Dole (R-KS) is a master at his profession, and I have utmost confidence that he will do a credible job as majority leader of the Senate. But I do worry about Representative Newt Gingrich (R-GA) as speaker of the House, for while he is a skilled politician and a compelling speaker, I would characterize him as a loose cannon. He needs humility and moderation.

On reflection, it may be that these politicians, who often judge our profession harshly as self-involved, reactionary, and out-of-touch, could take some lessons in humility, moderation, purposefulness, and solidarity from the recent proceedings of our Pennsylvania meeting.

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Taking the Long Road Back to Unity

John H. Hobart, MD

It seems I've started something of a trend—if you can call two columns a trend—by writing to you about things in my future and your past. I started off in October by noting the upcoming vote on unification in the House of Delegates, and as you know by now, the vote was made to remain unified with the American Medical Association.

This month, one of the concerns uppermost on my mind has to do with a meeting that will be past in time as you read this, but still very much part of the future of medicine in the commonwealth of Pennsylvania. I'm talking about the Specialty Society Leadership Summit on November 10 at Society headquarters. It was designed as a roundtable discussion, conducted by an independent facilitator, to determine how all segments of organized medicine can work together to achieve goals on behalf of all.

We wanted to explore the divisiveness within our profession and find out what drives wedges between us. And we wanted to identify some starting points for building new connections and learning perhaps better ways of speaking with a unified voice.

Quite candidly, I'm not quite sure how we got where we are today. Somewhere along the line, medical specialty societies seem to have become the perceived recruiting adversaries of state and county medical societies, hospital medical staff organizations, and the AMA.

Fragmentation comes from our failure to see where we are more alike than different. Sometimes I think this pulling apart of our profession far outshadows the challenges we face from outside.

While no one would deny that physicians of the same discipline of medicine have many clinical and practice problems in common, I would submit that the problems and frustrations of dealing with Medicare, Medicaid, the state Health and Welfare Departments, as well as "the Blues," are likewise matters that ought to draw all Pennsylvania physicians together.

> *"It is far more important that we demonstrate philosophical and political unity as we deal with the external forces that beset us."*

I've seen many changes in my time, but I believe it has never been more certain that only the Pennsylvania Medical Society and the AMA can effectively represent our profession at the state and national levels—and then only if given a true mandate by the majority of physicians. We must continually strive to become a more cohesive and effective force.

From time to time in recent years, various professional organizations of physicians have surprised their colleagues with sudden and unexpected announcements of policies on legislative matters, with no prior notification or discussion.

We must seek unity not in name only, but in deed, as well. Regardless of the unity we enjoy within our own organizations, it is far more important that we demonstrate philosophical and political unity as we deal with the external forces that beset us.

We are never content with divisiveness. We are always working to build bridges back to each other. We know in our hearts, I believe, that it is in all our best interests in the long run to stand together as a unified profession.

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December 7th
Steroid-Induced Osteoporosis
Paul Katz, M.D.
Professor of Medicine, Microbiology, and Immunology
Chief, Division of Rheumatology, Immunology, and Allergy
Georgetown University School of Medicine
Washington, DC

December 14th
Cardiac Auscultation
Leonard S. Dreifus, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Daniel Mason, M.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

Gerald Scharf, D.O.
Professor of Clinical Medicine
Division of Cardiovascular Diseases
Hahnemann University

John J. Ross, R.C.P.T
Research Assistant Professor
Division of Cardiovascular Diseases
Hahnemann University

December 21st
Metabolic Bone Disease - Osteodystrophies and Osteoporosis
Harmut Malluche, M.D.
Professor of Internal Medicine
Chief, Division of Nephrology, Bone and Mineral Metabolism
University of Kentucky
Lexington, KY

December 28th
No Grand Rounds—Holiday

JANUARY 1995

January 4th
Urinary Tract Infections
Donald Kaye, M.D.
Chair, Department of Medicine
Medical College of Pennsylvania and Hahnemann University School of Medicine

January 11th
Antibiotic Resistance
Robert C. Moellering, Jr., M.D.
Shields Warren-Mallinckrodt
Professor of Medical Research
Harvard Medical School
Physician-in-Chief
New England Deaconess Hospital
Boston, MA

January 18th
Aspirin and Warfarin Combined Therapy-Multicenter U.K. Trials
Thomas W. Meade, D.M., F.R.C.P.
Director, Medical Research Council
MRC Epidemiology and Medical Care Unit
Wolfson Insitute of Preventive Medicine
The Medical College of
St. Bartholomew's Hospital
London, England

Prevention and Treatment of Abnormalities of Thrombosis Cardiovascular Disease
Yale Nemerson, M.D.
Goodhart Professor of Medicine and Biochemistry
Chief, Division of Thrombosis
Research, Mt. Sinai Medical Center
New York, NY

January 25th
Complications of Drug Therapy in the Elderly
Michael F. Michelis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital
New York, NY

FEBRUARY 1995

February 1st
Goodpasture's and Aiport's Syndromes Revisited
Raymond M. Hakim, M.D.
Professor of Medicine
Vanderbilt School of Medicine
Division of Nephrology
Vanderbilt Medical Center
Nashville, TN

February 8th
Diseases of the Aorta and Peripheral Vasculature
Randall B. Griepp, M.D.
Professor and Chair of Surgery
Division of Cardiothoracic Surgery
Mt. Sinai Hospital
New York, NY

Medical and Surgical Management of Aortic Disease of Marfan's and Related Conditions
Reed E. Pyeritz, M.D.
Professor and Chair of Human Genetics
Professor of Medicine and Pediatrics
Medical College of Pennsylvania and Hahnemann University
Allegheny Singer Research Institute
Pittsburgh, PA

February 15th
Diabetic Nephropathy: Early Intervention and Prevention
Marc Pohl, M.D.
Professor of Medicine
Department of Nephrology and Hypertension
The Cleveland Clinic
Cleveland, OH

February 22nd
Treatment of Hyperlipidemia: Primary Prevention vs. Secondary Prevention
David Capuzzi, M.D., Ph.D.
Professor of Medicine
Medical College of Pennsylvania and Hahnemann University
Director, Lipid Disorders
Medical College of Pennsylvania Hospitals, Main Clinical Campus
Philadelphia, PA

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

DECEMBER 14, 1994
Cardiac Diagnostic Techniques for the Generalist Physician
Lecturers:
Leonard Dreifus, M.D., Daniel Mason, M.D., Gerald Scharf, D.O., John Ross, R.C.P.T

JANUARY 18, 1995
Prevention and Treatment of Abnormalities of Thrombosis in Cardiovascular Disease
Guest Lecturers:
Thomas W. Meade, D.M., F.R.C.P. and Yale Nemerson, M.D.

FEBRUARY 8, 1995
Diseases of the Aorta and Peripheral Vasculature
Guest Lecturers:
Randall B. Griepp, M.D. and Reed E. Pyeritz, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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LETTERS TO THE EDITOR

AND THE BAD NEWS IS...

...Health care reform is not dead. Hillary Clinton blames bad politics for the failure of a health care reform bill to make it to a vote before the recess. The latest announcement from the administration is that it will be back in 1995, but with the political error corrected: Mrs. Clinton and Ira Magaziner will remain in the background like puppeteers, pulling the strings—but you won't see them.

Mrs. Clinton added that people in this country had been trying for decades to get government-run, universally mandated health care through the Congress.

In her mania for power, Clinton does not recognize that since Wilbur Cohen first tried to socialize the entire provision of medical care in America in the mid-1930s, hundreds of millions of Americans have repeatedly fought to stave off the efforts of a few dozen members of the Congress, a few presidents, and various other "liberals," both within and outside of the political structure, who actively seek a politically dominated, government controlled, semi-European style of socialized medicine. Who in his right mind wants it? One more time we Americans have managed to convince a majority of members of the 103rd Congress that we did not even trust a vote on the matter lest something get slipped off on us as has so often happened before.

With health care reform going underground, the need for citizen vigilance is greater than ever. Just as three-fourths of Medicare/Medicaid legislation has been slipped through as riders on other bills, we can expect to find next year's health care reform bills tacked piecemeal onto bills such as those concerning public lands, banking, wetlands conservation, etc.

We're going to get it, folks; we're just not going to see it coming unless we go after the 104th Congress right away.

George C. Manning, MD
Fort Wayne, IN

QUALITY, FREEDOM: ARE WE SELLING OUR SOULS?

The article by Dr. Paul Kettl, "Separate, But Unequal" [October 1994, page 52], describing the failure to cover psychiatric patients adequately by insurance plans, was excellent indeed. One other point is that psychiatry is somewhat like surgery in that patients do not really like to see psychiatrists for various reasons, two of which are: Reactions to medications can be unpleasant, and there is still a stigma that is less but still exists. This reduces the utilization, often to the patient's disadvantage, so it is too bad to add the other determent, the lack of insurance coverage.

Regarding health insurance reform, do we fully realize that physicians (and patients) are going to be held captive by HMO-type schemes? For example, a doctor may develop special skills in a certain area or get along better with certain patients, but he or she will be unable to accept such patients who could benefit from his or her skills unless they belong to the insurance scheme to which he or she belongs. This will reduce the incentive to develop these skills further, and they will not be put to their maximum use.

In addition, patients will be unable to utilize the doctor's skills, so the patient is also a captive. All this reduces competition for quality, but reformers claimed they were increasing competition—or were they just referring to price?

This country was formed for the purpose of freedom from such captivity, but here we are reverting to that state. Are we, patients and doctors, selling our souls for a mess of potage?

Arthur C. Walsh, MD
Pittsburgh

SOME HABITS ARE DIRTY AND DANGEROUS

It seems part of our culture to lick our finger to turn pages of a book. I have seen Peter Jennings, the ABC anchorman, do it on the evening news; President Bush do it on national television while addressing the country; and countless doctors do it in the hospital while going through patients' charts. In the setting outside the hospital, this habit may be considered by many as unaesthetic at best, but inside a hospital it may be dangerous.

It is well known to the medical profession that the most dangerous bacteria in the human body reside in the mouth cavity. To wet one's fingers with the tongue while going through patients' charts or x-rays and then examine the patient is contradictory to all infectious disease prevention practices. I have seldom seen these health professionals wash their hands after going through the charts. The hospital abounds with dangerous microbes such as staphylococci, hepatitis B virus, and HIV. The practice of licking one's fingers, besides carrying saliva onto the patient charts, etc., may also carry these microbes into one's mouth.

I grant that I may sound unsympathetic to the people who have this habit, and some are going to get angry at me. Believe me, though, that my hands are more dry than an average person, and it does not take too much effort for me to turn the pages of a book or chart. *I am hoping that the editorial staff of this journal does not have this habit themselves because if they do, this letter may never see itself in print.*

My intention is not to offend anyone, but to appeal to them to think about the practice, and abandon it. In these days of Occupational Safety and Health Administration regulations requiring disposable bags for all biohazard material (anything with body fluids, including saliva), gloves, gowns, eye goggles, etc., the time has come for the demise of finger licking to turn pages. Finger licking while eating chicken may be good, but not while turning the pages of patient charts.

Incidentally, the habit of holding the cap of one's pen in the mouth while writing in the chart should be equally condemned.

Narayan Deshmukh, MD
Sayre

BOTTOM LINE IS: WHO PAYS THE DUES?

I would like to add an addendum to Dr. Murcek's well-written article ["The List Is Long Indeed," September 1994, page 8] supporting the federation of medicine.

The next time a legislator or lay person asserts "that the AMA doesn't represent the majority of physicians in America," I hope the listener will disagree. The AMA represents all physicians. Unfortunately, only 42 percent choose to pay the dues.

Charles Cutler, MD
Norristown

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Complexity of '90s Medicine Evident at Annual Meeting

Maria T. Montesano
Assistant Managing Editor

Extensive debate at the Pennsylvania Medical Society's annual business meeting, held in Hershey in October, reflected the complexity of the issues facing physicians in both the state and the nation: The role of managed care currently and in the future of medicine remains uncertain; added concerns over public health are more evident than ever; and while unification with the American Medical Association remains intact for 1995, membership issues require continued attention in the year to come. Engaged in the debate were 270 delegates of the Society's House of Delegates; their decisions on your behalf will guide the organization's 1995 efforts.

Prior to voting on issues in the House, delegates attend reference committee hearings where advocates and opponents debate their views on the various reports and resolutions. Business items then move to the floor of the House for further discussion and vote. This year the delegates adopted 70 reports and resolutions; the remainder were either referred for further study, not adopted, or filed.

Managed care garners debate

Those following state and national newspaper headlines in 1994 recognize that keeping up with almost daily health care mergers has proven challenging (for the latest news, see page 47). In an effort to take the lead in the changing health care environment, physicians are studying their options and professional relationships.

Two resolutions submitted to the House addressed such matters. Resolution 529 (94), introduced by members of the Bucks County Medical Society, called for the Society to endorse the establishment of a statewide "physician-owned health care delivery organization, such as an HMO"; Resolution 531 (94) from the Society's Young Physician Section (YPS) asked for a feasibility study of developing such an organization.

Donald H. Smith, MD, Easton, debuted as vice speaker of the House of Delegates at the Society's annual meeting in October in Hershey. He was elected to the position by the 1993 House.

Debate at the reference committee focused on, "What exactly would the Society be supporting?" Some physicians advocated specifically supporting the Pennsylvania Physician Healthcare Plan (PPHP), a Wyndmoor-based physician group studying the feasibility of forming a statewide physician-owned and physician-directed health insurance company. A majority of delegates, however, spoke in support of "the concept" of such an organization, so not to limit their options for future development.

YPS representatives also spoke in favor of the concept, saying that the issue is important to the future of young physicians, and requested support of Resolution 531 to *further* study the issue.

On the floor of the House, the delegates followed the reference committee's recommendation to adopt a substitute resolution in lieu of the two original resolutions. The substitute resolution directs the Society to "endorse the concept of physicians pursuing the establishment of Pennsylvania physician-owned health care delivery organizations."

The vote is consistent with the work of the Society's new subsidiary, the PennMed Member Services Company (PMSCO), which is currently assisting physicians with a variety of practice issues, from general practice management services to practice mergers, to establishing and managing physician-led multispecialty networks. Both efforts share the goal of seeking to put physicians in a strong position in the health care marketplace.

In response to YPS concerns, the State Society—primarily through PMSCO—will continue to monitor efforts and assist physicians who are working to establish physician-owned and physician-directed health care delivery organizations.

Any willing provider is hot issue

Recognizing that exclusion of providers from managed care contracts is a major issue—and a controversial one—among Pennsylvania physicians, the House adopted a board report which advocates a "middle ground" on the "any willing provider" issue.

Policy of the 1993 House of Delegates required the Society to include in its health system reform position "the concept that any willing health care provider/supplier be permitted to participate in health care networks/alliances, provided they meet basic quality assurance criteria." However, others strongly believe networks should have

Society Dues Unchanged in '95

The House of Delegates voted not to increase State Society dues in 1995, making it the fifth year in a row dues are set at $430 for the full-dues membership category. Dues remain unchanged for other categories of membership as well. As in the past, $10 of the assessment will be given to the Society's Educational and Scientific Trust.

unfettered discretion regarding who is admitted to a network.

The board, in its report to the House, said it believes that the interests of the *core* of the Society's membership and their patients will be best served by a solution that recognizes the legitimate concerns of *both* sides.

The board report included five recommendations, which were adopted by the House:

"a) The Society endorses AMA policies advocating criteria primarily based on professional competence and quality of care, due process, and physician input from a network 'medical staff' regarding both the criteria and the process;

b) Managed care networks should not be permitted to require physicians to have hospital admitting privileges in those areas of the state where it is impractical for the physician to maintain such privileges or where such a requirement could aggravate a physician shortage;

c) Managed care networks should be required to waive board-certification requirements in those areas of the state where such a requirement could aggravate a physician shortage;

d) The Society should seek legislatively mandated safeguards, including the protections called for in the above policies, to protect providers from arbitrary exclusion from managed care networks; and

e) The Society reiterates its position that individuals must be free to choose from a full range of health care coverage plans and should not be forced into a plan that limits their choice of provider or misled into selecting such a plan."

In related action, the House adopted without debate Resolution 518 (94), calling for a study of the following "any willing facility" policy: "That any willing credentialed facility be given the opportunity to apply to any health plan or network and have that application approved if it conforms with the fee schedule and quality mechanisms set forth by the plan."

Public health focus: violence, smoking

Public health issues remain a priority for Pennsylvania physicians. The House resolved this year to act on two important issues affecting patients and physicians—tobacco use and violence against physicians.

At left: Ronald J. Clearfield, MD, New Kensington, chaired the Reference Committee on Bylaws, which dealt with the issue of unification and other proposed bylaws changes. Above: Board Chair John W. Lawrence, MD, was one of a large contingent in support of deunification from the AMA.

In response to a Philadelphia County Medical Society resolution, the House has directed the Society to encourage local governments to enact anti-tobacco ordinances. Further, the Society will oppose any legislation that would preclude "sting" operations to enforce age limits on tobacco sales. Instead, the Society will solicit support from parent-teacher organizations in its efforts to make schools tobacco free.

Engaged in debate at the Society's annual meeting were 270 delegates of the Society's House. Their decisions on your behalf will guide the organization's efforts in 1995.

These actions are a continuation of Society efforts to curb tobacco use and reflect the AMA's goal of a "smoke-free society by the year 2000." In the past, the Society has supported anti-tobacco legislation and has frequently testified before legislative committees on tobacco concerns.

In other efforts, the Society is a partner in the state Department of Health's Youth Against Tobacco campaign, which encourages teenagers not to use tobacco products. Also, the Society leads a program which recognizes pharmacies which promise not to sell tobacco products (see pages 51-53) and is a member of the Coalition for a Tobacco-Free Pennsylvania.

Regarding violence against physicians—a growing concern among physicians, especially in light of the summer killing of a physician in front of a Florida clinic—the delegates discussed the need for unbiased, complete information about the problem. They voted to have the AMA collect and publish data on incidence of threats and/or violence against physicians so to better "understand the magnitude of this problem and be better able to protect the well-being, safety, and possibly the lives of ourselves and our colleagues."

State Society stays unified

One of the most hotly debated issues of the annual meeting was whether the State Society should remain unified with the AMA.

Resolution 101 (94) called for the Society to "make the necessary bylaws change that will allow the membership the freedom of choice as to whether or not they desire to be a member of the AMA, Pennsylvania Medical Society, and/or the county medical society." The Delaware County Medical Society proposed a similar change to break the tie with the national organization.

Lengthy debate at the Reference Committee on Bylaws focused on several issues. Some physicians testified against unification, citing philosophical differences in opinion with AMA policies; others cited declining membership and the cost of joining all three organizations as reasons to allow freedom of choice.

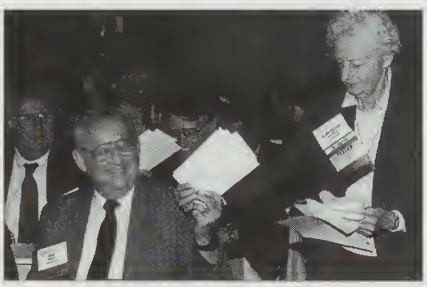
But advocates of unification argued it was "critical" to maintain the national tie, to work with physicians nationwide for the "good of the

Dr. Seward

profession." Others questioned the validity of blaming unification for the decline in state membership. In the end, the House voted not to deunify.

The delegates also approved a recommendation of the reference committee that the board establish a committee to study the issue of deunification and include results of an AMA consortium studying the structure of the federation.

Immediately following the vote, P. John Seward, MD, chair of the AMA's Board of Trustees, responded to the House action: "I am often asked by physicians, 'If we deunify, would the AMA abandon us?' My answer," he said, "is that the AMA never abandons any American doctor, member or nonmember." He added that he appreciated the confidence in the AMA demonstrated by the vote and that he would take members' concerns back to AMA leadership, "because these are concerns for all of medicine."



Delegate Robert Kemp, MD (left), Lancaster County, passes paper ballots to Volunteer Teller Gertrude Blumenschein, MD (right), Fayette County, during a close House vote.

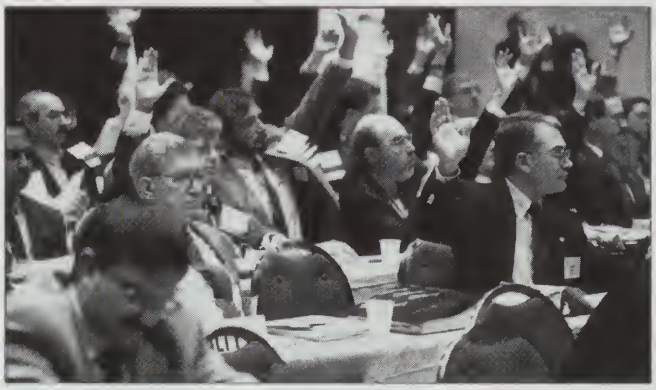
Membership-driven process

To enhance the Society's vitality as it moves into the twenty-first century, the House approved recommendations generated by activities of the Society's Task Force to Enhance Physician Involvement. This task force was established two years ago to study physicians' decreasing involvement in organized medicine, the relevancy of Society membership to physicians, and the need for increased focus by the Society to involve more physicians at the grassroots level.

After extensive research, including focus groups of members, nonmembers, and ex-members, the task force said key findings suggested that the Society is perceived as:

- reactive, rather than proactive;
- inadequately soliciting and incorporating input from the grassroots;
- under-representing physician diversity in leadership positions; and
- failing to breakdown communication barriers between the Society and the ever-increasing number of employed and group practice physicians.

The task force also found that physicians in groups do not perceive the value in membership and that salaried physicians have less flexibility in finding time for Society meetings.



Delegates raise their hands in support of one of 70 reports and resolutions adopted at this year's annual session.

Following further examination of the findings and related information, the task force pin-pointed two root causes for the Society's lack of physician involvement:

1) The Society does not truly understand what members value and consider to be a good return on the investment for the typical Society member.

2) The Society, in its attempt to be all things to all members, is perceived as being unfocused and unable to deliver in meaningful ways.

Further study of the Society's methods of prioritizing, communications, allocation of resources, and organizational discipline showed that the Society has largely functioned as a *member*-driven organization—attempting to be all things to all members, always saying yes, and avoiding conflict—instead of a *membership*-driven organization—practicing prioritization, encouraging bottom-up communications, soliciting constant feedback, responding willingly to change, exercising flexibility, and emphasizing accountability.

The task force concluded that a key to the Society's success may rest in the organization's ability to become *membership*-driven—to become an organization that physicians *want* to join because they perceive value in the Society and its initiatives. To achieve this, the Society will undertake four major initiatives:

1) prioritize initiatives based on identified membership needs;

2) expand two-way membership communications, emphasizing grassroots input;

3) allocate staff and fiscal resources to support membership priorities; and

4) streamline infrastructure to respond quickly to changing membership priorities.

An essential and crucial element the Society will use to help prioritize and achieve a membership-driven organization is the "membership-driven process (MDP)." The process will result in obtaining grassroots input, analyzing information, establishing priorities, acting on established priorities, and providing feedback to the membership.

As directed by the House's approval, these initiatives will begin in 1995 and are anticipated to result in a long-term, positive impact for the membership. A nuts-and-bolts introduction to the process is slated for publication in the January issue of PENNSYLVANIA MEDICINE.

In other membership-related action, the House approved a new membership category for practice administrators.

Stacy M. Wenger, the Society's assistant director of medical staff relations, contributed to this article.

RESIDENTS ATTEND NCRPO; SECTIONS DISCUSS POLICY

In October, the Society's Resident Physician Section (RPS) participated in the fourth National Consortium of Resident Physician Organizations

(NCRPO). Attending were resident physician chairs and other representatives of state and specialty societies.

Sponsored by the Bureau of Health Professions, the NCRPO has a mission to increase dialogue among resident physician organizations so that members of these groups can share educational, leadership, and socioeconomic experiences, and to encourage the development of resident physician organizations. The fifth meeting of the NCRPO will be held in Washington, DC, in the fall of 1995.

Elections for the RPS Governing Council took place at the section's annual meeting, held in conjunction with the annual business meeting in Hershey in October. Newly elected officers are: Stuart Gitlow, MD, MPH, chair; Eric Gertner, MD, vice chair; and Elizabeth Sinz, MD, secretary. Joyann Kroser, MD, is serving her second year as resident trustee, and Jennifer E. Trottman, MD, is past chair.

Also serving the section are: Jerome A. Schroeder, MD, Ajay Goyal, MD, Jill B. Cohen, DO, Patricia A. Graham, MD, E. Mark Hekler, MD, and Steven C. Thornquist, MD, members-at-large; and Bradley D. Stein, MD, Sunil K. Saini, MD, Binoy K. Singh, MD, Brian A. McConnell, MD, Atulkumar M. Kshatri, MD, and Jeffrey S. Plotkin, MD, alternate delegates.

Residents interested in becoming more active in the section may contact any member of the Governing Council for more information. Those with Internet access can contact Dr. Gitlow directly at afagitlow@aol.com.

Young Physician Section

The Society's Young Physician Section (YPS) also met during the Society's annual meeting. Thirty young physicians attended the Eighth Assembly of the YPS on October 20.

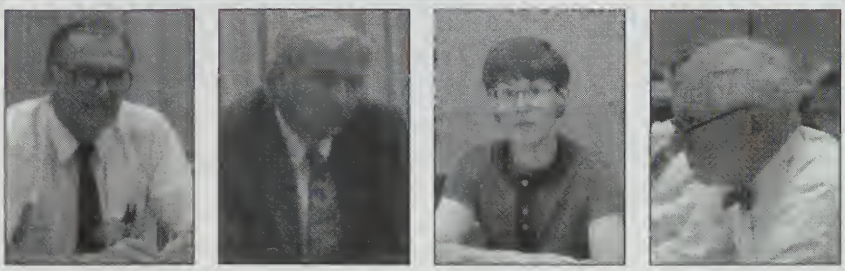
The section reviewed annual business meeting materials and agreed to support the right of State Society members to freely choose whether of not to join the AMA. It also approved a resolution on statewide physician-owned/managed PPOs, which moved to the House as Resolution 531 and was incorporated into Substitute Resolution 529. A second resolution from the section dealing with restrictive covenants in medicine was referred for study by the full House.

David Shulkin, MD, Philadelphia, led an afternoon educational session on "Improving Cost-Effective Clinical Decision Making." The seminar was developed to give participants the skills to address these issues in their practices; Dr. Shulkin designed case studies for attendees to review and discuss.

Elected officers of the YPS Governing Council are: William J. West Jr. MD, chair; Mark A. Piasio, MD, vice chair; and Mary J. Hudak, MD, secretary. Robert M. McNamara, MD, was newly elected trustee representative, and Arthur V. Stein, MD, is past chair.

Also serving the section are: Jeffrey H. Baker, MD, Chris W. Fellin, MD, Marlon T. Maus, MD, and Martin D. Trichtinger, MD, delegates; Daniel J. Glunk, MD, member-at-large; and Stuart Gitlow, MD, Joseph K. Izes, MD, Andrew R. Levette, MD, and Carl A. Sirio, MD, alternate delegates.

HMSS NEWS



Sixty-one representatives attended the Hospital Medical Staff Section (HMSS) meeting on October 20 to discuss such issues as the appropriate roles of nursing administration and the medical staff in hospital quality assurance activities, the role of the medical staff in hospital CQI/TQM activities, and certificate of need for the development of ambulatory surgical facilities. The assembly considered six resolutions; five were adopted by the section, four were adopted by the House. The meeting concluded with a four-hour seminar, "How to Build Effective Coalitions and Negotiating to Succeed." Elected officers and members of the HMSS Governing Council are (left to right): James G. Pitcavage, MD, chair; John W. Lehman, vice-chair; Wilma C. Light, MD, secretary; and William W. Lander, MD, member-at-large.

Medical Student Section

Forty medical students attended the Medical Student Section assembly, also held on October 20. Highlighting the agenda was the educational program, "Preparing Yourself for the Future of Medicine."

Paul Rudolf, MD, chair-elect of the AMA's Governing Council, spoke to students about keeping up to date on the changing medical marketplace and new happenings in medicine. According to Dr. Rudolf, this will help students better choose types of practice.

Elected officers of the MSS Governing Council are: Kenneth W. Anderson, chair and Stephen W. McManus, vice chair. Stacy L. Krisher is serving her second year as student trustee, and Randolph B. Wood is past chair.

Also serving the section are: Kimberly W. Schlesinger, alternate delegate; and Heather L. Orman, Kasai S. Sudol, James R. Baer, Tina J. Allen, Andrew F. Vaughn, and Heidi Handel, members-at-large.

Stuart Gitlow, MD, chair of the Society's Resident Physician Section, contributed the RPS portion of this article.

ANNUAL MEETING STATS

The following county medical societies reported 100 percent attendance at the Society's annual meeting: Adams, Beaver, Berks, Bucks, Centre, Chester, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Erie, Indiana, Lawrence, Lehigh, Luzerne, Lycoming, Mercer, Monroe, Montour, Northampton, Northumberland, Schuylkill, Tioga, Venango, Westmoreland, and York.

ACTIONS OF THE BOARD OF TRUSTEES

LEGISLATION, MANAGED CARE TOP LIST OF '95 GOALS

The Board of Trustees at its October 21 meeting approved the following Society priorities for 1995:

- Legislation focusing on health system reform, medical liability reforms, managed care safeguards,

Westmoreland County Delegates Donald C. Brown, MD (left), and John S. Parker, MD (right), discuss House proceedings; both serve the Pennsylvania Delegation to the AMA—Dr. Brown as vice chair and Dr. Parker as a member of the delegation.

utilization review standards, and allied health scope of practice.

- Managed care: Continued support for the development and expansion of PMSCO services; empowerment of Pennsylvania physicians through education on the changing health care marketplace and strategic medical practice decision making; and expand the role of organized medical staff section to managed care entities.
- Membership: Recruitment and retention of all physicians.
- Expansion of non-dues revenue.
- Public health issues.
- Third-party reimbursement issues.

Priorities are determined each year as guidance for the Pennsylvania Medical Society's overall activities, but by no means limit the range of issues addressed by the Society. The House of Delegates passed a resolution calling for future priorities to be submitted to it as a separate and free-standing item of business.

Other action

In other action at the meeting, the board discussed the Society's pilot membership programs for group practices and approved in principle a series of recommendations from the Young Physician Section (YPS).

The Council on Membership has developed several pilot membership programs over the past year to recruit new members. Its latest program is an attempt to meet the growing involvement of physicians in group practices.

As a starting point, the board reaffirmed the AMA's definition of group practice as "...three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records, and personnel are shared. Income [is] distributed by some prearranged plan." The board also agreed that independent practice associations (IPAs), "clinics without walls," and other similar group structures should also be part of the group practice pilot membership program.

In response to the Society's new "membership-driven process" (see overview, page 14), the YPS developed a series of recommendations asking the Society to:

- consider membership of young physicians as a priority;
- assure adequate representation of young physicians in the membership-driven process;
- solicit grassroots input from young physicians throughout the state in order to assist the Society in becoming more effective for its members and future members;
- direct, as appropriate, existing resources to increase and find new ways to communicate with young physicians across the state; and
- support and provide resources for YPS leadership initiatives for the young physicians in Pennsylvania.

The board approved in principle the recommendations.

Reorganization

At a reorganizational meeting following the last session of the 1994 House of Delegates on October 23, the board re-elected John W. Lawrence, MD, chair, and Ferdinand L. Soisson Jr., MD, secretary. Dr. Lawrence, Second District, returns as chair for his third term; Dr. Soisson, Eleventh District, returns as secretary for his sixth term. Also, James R. Regan, MD, Interspecialty Section, was newly elected vice chair of the board.

Election Results

The State Society House of Delegates elected the following new officers and delegates during its October 1994 meeting:

President: John H. Hobart, MD, Northampton County

President Elect: Jonathan E. Rhoads Jr., MD, York County

Vice President: Victor F. Greco, MD, Luzerne County

Speaker of the House: Howard A. Richter, MD, Delaware County

Vice Speaker of the House: Donald H. Smith, MD, Northampton County

New Trustees:
John A. Malcolm Jr., MD, Seventh District
Edward A. Lottick, MD, Twelfth District
Robert M. McNamara, MD, Young Physician Section

Delegates to the AMA/County:
R. William Alexander, MD, Berks
Richard D. Baltz, MD, Dauphin
Doris G. Bartuska, MD, Philadelphia
Joseph B. Blood Jr., MD, Bradford
Betty L. Cottle, MD, Blair
James B. Donaldson, MD, Philadelphia
Victor F. Greco, MD, Luzerne
Lee H. McCormick, MD, Allegheny
John S. Parker, MD, Westmoreland
Howard A. Richter, MD, Delaware
Carl A. Sirio, MD, Allegheny
Donald H. Smith, MD, Northampton

Alternate Delegates to the AMA:
George F. Buerger Jr., MD, Allegheny
Charles J. Cattano, MD, Allegheny
Robert G. Doe, MD, Lancaster
Carl A. Frankel, MD, Dauphin
Thomas F. Freenock Jr., MD, Delaware
Mark S. Friedlander, MD, Delaware
Andrew W. Gurman, MD, Blair
Virginia E. Hall, MD, Dauphin
Lila S. Kroser, MD, Philadelphia
John A. Malcolm Jr., MD, Union
Ferdinand L. Soisson Jr., MD, Cambria

Alternate Delegate, Resident:
Jennifer E. Trottman, MD, Montgomery

Alternate Delegate, Student:
Kimberly W. Schlesinger, Allegheny

Committee to Nominate Delegates and Alternates to the AMA:
Gilbert A. Friday Jr., MD, Allegheny
Donald E. Parlee, MD, Bucks
Gloria J. Watkins, MD, Westmoreland

Judicial Council:
David W. Clare, MD, Allegheny
Raymond C. Grandon, MD, Dauphin

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Working Together for Change

John H. Hobart, MD

This is an excerpt from Dr. Hobart's inaugural address presented on October 21 to the Society's House of Delegates at its annual meeting.

It is not easy to comment about some of the very significant and meaningful decisions that this House will be addressing in the next three days. Nevertheless, there are several concerns on all of our minds, and I would like to at least touch upon each one for a moment or two.

Membership

First is the issue of membership...a matter of intense concern, and one that will remain at the center of Society efforts this year.

Our percentage of membership among young physicians is well below what we would hope and expect from that section of our physician population. We are working hard to find new ways to attract more young physicians—and to keep them as active, involved members.

I would like to acknowledge the work of the Task Force to Enhance Physician Involvement and the subsequent refinement of their recommendations at the board retreat in July. Many hours and much effort have been expended in this and other forums to address our membership concerns.

You will hear the details of these efforts in your reference committees, but I can give you the bottom line right now, which is: We are all in this together. Those of us who have benefited from the rewards of our profession are not standing by, leaving our younger colleagues to struggle alone. Our labors may be of the present moment, but our concern is the future of our profession and of our patients.

Tort reform

This leads me to the second concern—the issue of tort reform.

I am not infrequently faced with physician groups that tell me we don't really need to do anything with regard to tort reform this year—or even next year. My response is: Time Out.

Tort reform is not a stagnant subject that is not going to rear its ugly head unless and until it is prodded by physicians. May I remind you of the trial bar and its very powerful lobby, which is always seeking to enhance its position through such efforts as exploring new theories of malpractice law and new forms of coverage. The trial bar is also both vigilant and active in its efforts in the legislative arena. But change may come from other directions as well.

> ***"If physicians do not take a proactive stance on tort reform, we will find ourselves in the position of trying to catch up with the gains of the other side."***

The state CAT Fund is advocating an increase in basic limits because of its fears of the need for an emergency surcharge. This probably would mean a significant increase in primary level premiums. And the money would go largely to fund the legal system.

If physicians do not take a proactive stance on tort reform, we will find ourselves in the position of trying to catch up with the gains of the other side. Indeed, most of our advocacy positions seek only to level the playing field. So tort reform is, and will remain, a key concern of the Pennsylvania Medical Society.

Continued on page 20

Dr. Hobart, an Easton urologist, is the Society's 145th president.

Support, Cooperation Are Keys to Survival

Martin A. Murcek, MD

This is an excerpt from Dr. Murcek's exaugural address presented on October 21 to the Society's House of Delegates at its annual meeting.

In my inaugural address, I stated that I had no specific personal agenda to pursue during my year as president of the Pennsylvania Medical Society. Instead, I identified several ongoing initiatives of the Society that deserved attention, as well as the unprecedented assault on the medical profession, in the guise of health system reform.

Society "wins"

I am proud to look back on the past year, and count several major successes of the Society's work. The favorable outcomes that were achieved are a strong testament to the quality of the Society's staff, as knowledgeable and determined a group as the physicians of Pennsylvania could hope to have working for them.

The first major success I want to mention is the court battle the Society fought against the state Department of Public Welfare (DPW). In instances where elderly patients qualified for both Medicare and Medicaid, DPW was paying only the lower rates authorized by Medicaid, in contradiction of federal law. The court ruled that DPW must pay both the Medicaid and Medicare deductibles and co-insurance fees. This ruling amounts to $45 million annually for Pennsylvania physicians.

Our second important win came when we successfully stood up to an outrageous demand by Pennsylvania Blue Shield that physicians in this state re-pay $4 million in clinical lab test fees that Blue Shield overpaid during a three-year period. Although the mistake was theirs, Blue Shield and the Health Care Financing Administration contended that physicians should have recognized that they were being overpaid, and should be made to pay the money back with interest. Obscure regulations, buried in thousands of pages of procedural manuals, were cited in support of this bizarre position. In the end, the hearing examiner sided with the AMA-State Society joint appeal of the issue.

The third major win of the year came in July, when the Society persuaded DPW to delay the implementation of a new regulation that requires physicians to get a prior authorization number for certain Medicaid prescriptions. DPW sent out the instructions on how physicians should act to comply with this regulation on the day the regulation was to have gone into effect. The Society got DPW to admit that it wasn't fair to enforce a regulation that nobody knew how to comply with, and a two-week delay in implementation was granted.

In many ways, I believe the fourth big victory we scored this year was the most important in terms of ensuring our patients' health. The Society successfully blocked efforts to introduce legislation that would have substantially relaxed physician oversight of physical therapists, registered nurse practitioners, and other ancillary health care personnel. Under the various proposals being considered, CRNPs would have been allowed to practice medicine as independent primary caregivers. In addition, they would have had unlimited prescription privileges. Our position was, "If they want to prescribe, let them go to medical school, graduate, and meet all other requirements to obtain a medical license."

The common theme of all these efforts is the never-ending encroachment of bureaucratic meddling with the autonomy of physicians. Each of these cases is a microcosm of the great battle of the year, the fight to stave off the Clintons' health reform plan.

Health system reform

When I was sworn in as president of the Society, it seemed a near certainty that a big, socialistic, government-managed health system was just around the corner. One year later, the Clintons' proposal died on the steps of the White House. The plan's

Continued on next page

Dr. Murcek, a Greensburg allergist, is immediate past president of the Society.

Working Together for Change
Dr. Hobart (continued from page 18)

Unification

The question before us now is not the same as it was five years ago. The question, rather, is this: Is unification *still* in the best interest of the physicians of Pennsylvania? The vote on unification must be on the question of unification *today,* not unification five years ago. Is unification in 1994 a good thing? There are no easy answers.

I hope you have looked long and hard at the membership material...which you have received today. If you have, you know that reasons for the rise and fall of membership are impossible to completely define. And even after changes have occurred, it is not always possible to dissect the causes and determine exactly which were the most critical factors. In fact, the evidence suggests there are many reasons why physicians join or do not join their professional associations. And we continue working to identify and address every factor that would seem to affect our membership statistics.

Certainly, there is risk involved both in the vote to deunify and in the vote to remain unified. Your State Society is prepared for either outcome. But I would note that neither vote supports the status quo. Change is necessary to meet this changing environment.

Regardless of the vote here, your State Society cannot do other than continue to develop new strategies for meeting the challenges which the future surely has in store for our profession. That said, I will put the issue aside, as I have every confidence that the House will vote for what it believes to be the best course for the physicians of Pennsylvania.

Thank you for the opportunity to serve as your president in the coming year. And I would close with one final admonition—please stay in touch.

Support, Cooperation Are Keys...
Dr. Murcek (continued from page 19)

backers identify us as the bad guys who killed this supposed great boon for every man, woman, and child in America. In one sense, I wish we were that powerful. If we were, we could seize control of the reform debate and get something meaningful and fair for all proposed in Congress. What the Clinton plan backers are unable to admit, however, is that the Clinton plan was its own undoing. It was such a bad idea that it collapsed under its own weight—and the scrutiny of the American people.

When it looked like Clinton-Care was going to be railroaded through the House and Senate, I urged all of you to educate your patients about the dangers of the plan, and to mobilize your patients to pressure their representatives and senators in Washington, DC, to reject any part of the Clinton plan that was bad for their access to health care. I know a lot of you took me up on that, because I received plenty of reports in the course of my travels about the concerns being voiced by your patients, and about the calls and letters they directed to Washington.

It is important to keep in mind that the health reform fight will never be over. The people who want the government to control health care financing and delivery in this country will be back again. The lessons they learned in this failed attempt will make them stronger in the future. It is possible that they will attempt to implement their plans one small piece at a time, rather than in one grand sweep. That possibility demonstrates why the four successes I have mentioned are so important. The AMA, the State Society, and all physicians in Pennsylvania and other states must continue to make the promulgation and implementation of onerous regulations as difficult and politically costly as possible. We must stand up to the bureaucrats, and in doing so, wear them down.

"We must stand up to the bureaucrats, and in doing so, wear them down."

While the government, at both the federal and state levels, has been knocked back to square one on health care, I am still concerned about what may be forthcoming from the large insurance companies and hospitals. They would like nothing better than to own us as employees. No matter how much we protest, quality of care suffers with the loss of autonomy, personal and professional freedom, and professionalism, that seem to be inevitable when such employment of physicians occurs.

We have to keep our county, state, and national organizations viable by promoting membership and paying our dues. We also have to make sure we have leadership that is committed to a cooperative effort, as opposed to a bunch of "little kings" obsessed with building up their own little fiefdoms.

In conclusion, this has been one very busy year. Our accomplishments give me a great feeling of pride and of optimism for the future.

Resolutions Before the 1994 House of Delegates

This is an overview of actions from the October 21-23 annual meeting in Hershey.

Bylaws

101 (94): Physician Freedom of Choice. Calls for bylaws changes allowing members freedom of choice regarding membership in American Medical Association, Pennsylvania Medical Society, and county medical societies. *Not adopted.*

102 (94): County Medical Society Membership for Osteopathic Physicians. Would allow osteopathic physicians in good standing with their state and national associations to join county medical societies. *Referred to the board.*

103 (94): Deunification. Calls for a report to the 1995 House addressing the overall issue in light of an upcoming report by the AMA Consortium. *Adopted as amended.*

104 (94): Disciplinary Procedures. Calls for bylaws change requiring district board of censors to receive cases for original jurisdiction when requested to do so by a county board of censors; also recommends Judicial Council policy that county board of censors accumulate key facts of a case and not simply function as a pass-through entity. *Adopted as amended.*

Education and Science

201 (94): State Regulation of Laboratories. Calls for the Society to encourage and work for reform of more stringent regulations to make them consistent with CLIA standards, especially regarding waivered tests in physician offices. *Adopted.*

202 (94): Pharmaceutical Firms' Indigent Patient Programs. Calls for the AMA to seek standard industry-wide applications and guidelines for these programs. *Substitute resolution adopted.*

203 (94): Confidentiality of Electronic Recordkeeping. Calls for a study and report on options for protecting patient data, and possible drafting and support of related legislation. *Substitute resolution adopted.*

204 (94): Transmission of Medical Information. Calls for the Society to work with others to encourage modern means of transmission and to develop safeguards for confidentiality. *Substitute resolution adopted.*

205 (94): Continuing Medical Education. Calls for recognition of AOA- and ACCME-approved CME credits for licensure requirements. *Adopted.*

206 (94): Accreditation of Graduate Medical Education Programs. Seeks policy that it is inappropriate to use the residency review committee to control the number of physicians in any specialty or field of practice. *Referred to the board.*

Facilities/Peer Review

301 (94): User-Friendly Physician Review for Medical Staffs. Calls for copies of all medical staff minutes to be stored in medical staff office and made available to all medical staff physicians, except for redaction to preserve confidentiality or proprietary rights. *Referred to the board.*

302 (94): Physician Review for Medical Staffs. Calls for copies of all medical staff minutes to be available to all medical staff physicians, except for redaction to preserve confidentiality or proprietary rights. *Referred to the board.*

303 (94): Medical Director Clinical Qualifications, Roles, Responsibilities, and Duties. Calls for the Society to adopt AMA policies regarding the role of hospital medical directors, and medical directors of managed care plans. *Adopted as amended.*

304 (94): Medical Staff Self-Governance. Calls for the Society to adopt policy that voting members of a hospital's medical executive committee must, themselves, have been elected by either the medical staff or by a subset thereof. *Adopted.*

305 (94): Medical Staff Model Bylaws—I. Calls for the Society to adopt policy that: 1) physicians under investigation by the hospital medical executive committee be promptly notified and given the opportunity for an interview; and 2) medical staff quality improvement committees arrange for external review, when appropriate, and medical executive committee investigations be focused on the issue which initiated the investigation. *Adopted.*

306 (94): Medical Staff Model Bylaws—II. Calls for the Society to adopt the policy that when a quality improvement committee questions a physician's clinical behavior or actions, it must: 1) raise the specific concern in its initial query and deal with the individual case(s) when addressing the physician's response; and 2) offer the physician the opportunity to appear in person at its next or special meeting if he/she wants to discuss the situation. *Not adopted.*

Legislation/Regulation/ Professional Liability

401 (94): Physician Lobbyist. Calls for employment of physicians in active full- or part-time practice as lobbyists. *Not adopted.*

402 (94): Limiting Medical Records Access. Calls for Society to seek legislation allowing for summaries of medical records in response to inquiries, except when full records are required for litigation. *Substitute resolution adopted.*

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403 (94): Medical Examiner System. Calls for continued support of legislation to create such a system in Allegheny County, and efforts to resolve differences with those who oppose replacement of the current elected coroner system. *Adopted.*

404 (94): Protecting Raw Material Suppliers from Product Liability Litigation. Calls for support of the Biomaterials Access Assurance Act of 1994, which offers such protection. *Adopted as amended.*

405 (94): Insurance Forms. Calls for recommendation to prohibit insurance companies from requiring use of complex forms without proper compensation for time and skill required. *Substitute resolution adopted.*

406 (94): Patient Charts. Calls for recommendation to ban release of patient charts to insurers. *Substitute resolution adopted.*

407 (94): CAT Fund. Calls for solicitation of $5 from each Pennsylvania physician to help fund a CAT Fund legal action. *Referred to the board for further study.*

408 (94): Restrictive Covenants. Calls for the Society to seek state legislation to regulate the use of restrictive covenants in physician contracts, and report back to the 1995 House. *Amended and referred to the board for further study.*

Medical Economics

501 (94): CPT Evaluation and Management Code Revision. Calls for the Society to communicate through the AMA strong objections to specific difficulties with E/M codes and for the AMA to simplify and streamline coding decision-making processes. *Not adopted.*

502 (94): Physicians Choosing Whether To Bill Medicare Co-Pay. Calls for working with HCFA to remove the co-pay billing requirement and allow physicians to use their own discretion. *Not adopted.*

503 (94): Unified Credentialing. Calls for the Society to work with third-party payers, hospitals, and managed care plans to develop a universally accepted credentialing process. *Referred to the board for further study.*

504 (94): Coverage for Routine Annual Gynecological Exams and Pap Smears. Calls for a resolution to the AMA petitioning HCFA to provide Medicare coverage for these. *Adopted as amended.*

505 (94): Hospital Observation Services to Medical Assistance Recipients. Calls for petitioning of the state Department of Welfare to recognize and reimburse physicians for these services. *Adopted.*

506 (94): Medicare Reimbursement for Phone Calls. Calls for a request to the AMA to petition HCFA for a review of their current reimbursement policy to allow more adequate reimbursement for calls to patients and families. *Reaffirmed.*

507 (94): RBRVS Nursing Home Reimbursement. Calls for a petition to HCFA for an increase of 25 percent above the current reimbursement rate for physician visits to nursing homes. *Adopted as amended.*

508 (94): Independent Review of Third-Party Payers. Calls for regulations or legislation to establish same to review adverse decisions and make binding decisions. *Adopted.*

509 (94): The Third Opinion. Calls for reimbursement if first two differ substantially. *Adopted as amended.*

510 (94): Medical Directors of Managed Care Plans. Requires licensure in the state in which the patient is being treated. *Substitute resolution adopted.*

511 (94): Prolonged Detention While Providing Home Care. Calls for the Society and AMA to seek a CPT category of reimbursement for such services. *Substitute resolution adopted.*

512 (94): Freedom of Choice. Calls for adoption of policy to require employers or health alliances to offer at least two affordable health insurance plans in each generic category (fee-for-service, HMO, PPO, etc.). *Not adopted.*

513 (94): Utilization Review Appeals Under Managed Care. Calls for all physicians and patients to have access to reconsideration/appeals mechanism. *Substitute resolution adopted.*

514 (94): Pennsylvania Blue Shield. Calls for Medicare carriers to bear costs of their own errors and elimination of "hold harmless" clauses from contracts. *Adopted.*

515 (94): Study and Compare Single Payer to Managed Care. Calls for a committee to compare advantages and disadvantages of Medicare and the Canadian system, and report back to the 1995 House. *Not adopted.*

516 (94): Single-Payer System. Calls for support of a national nonprofit system with unrestricted choice and caps on administrators' salaries. *Withdrawn.*

517 (94): Independent Review of Denials by Third-Party Payers. Calls for establishment of a state independent appeal board where physicians, hospitals, and patients may seek binding resolution of these disputes. *Substitute resolution adopted.*

518 (94): Any Willing Facility. Calls for establishment of policy similar to any willing provider. *Adopted.*

519 (94): Reducing Uninsureds by Extending Medicaid. Calls for extending Medicaid eligibility to every Pennsylvanian, and eventually every American, with income below the official poverty level. *Substitute resolution adopted.*

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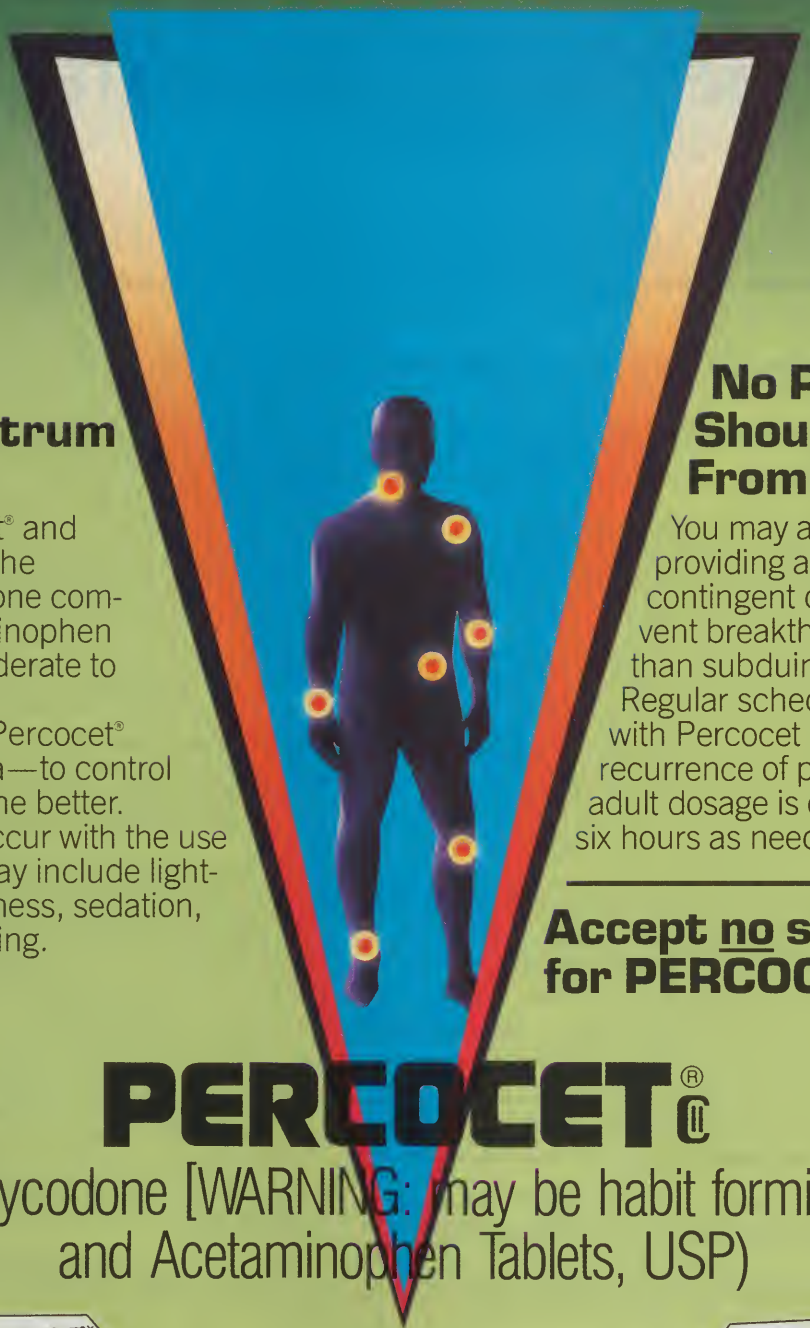

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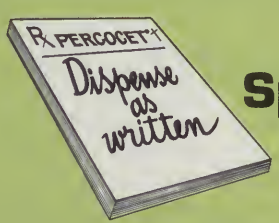

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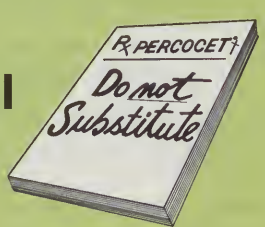

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CONTROL PAIN.
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REFERENCE:

1. Acute Pain Management Guidelines Panel. *Acute Pain Management in Adults: Operative Procedures. Quick Reference Guide for Clinicians.* AHCPR Pub. No 92-0019, pg. 12. Rockville, Md: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.

BRIEF SUMMARY

PERCOCET® (Oxycodone (**WARNING:** may be habit forming) and Acetaminophen Tablets, USP)

INDICATIONS AND USAGE PERCOCET is indicated for the relief of moderate to moderately severe pain.

CONTRAINDICATIONS PERCOCET should not be administered to patients who are hypersensitive to oxycodone or acetaminophen.

WARNINGS Drug Dependence: Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET is subject to the Federal Con-trolled Substances Act (Schedule II).

PRECAUTIONS General: *Head Injury and Increased Intracranial Pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of PERCOCET or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients: PERCOCET should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET should be cautioned accordingly.

Drug Interactions: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with oxycodone preparations may increase the effect of either the antidepressant or oxycodone.

The concurrent use of anticholinergics with narcotics may produce paralytic ileus.

Usage in Pregnancy Pregnancy Category C: Animal reproductive studies have not been conducted with PERCOCET. It is also not known whether PERCOCET can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. PERCOCET should not be given to a pregnant woman unless in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nonteratogenic Effects: Use of narcotics during pregnancy may produce physical dependence in the neonate.

Labor and Delivery: As with all narcotics, administration of PERCOCET (oxycodone and acetaminophen tablets, USP) to the mother shortly before delivery may result in some degree of respiratory depression in the newborn and the mother, especially if higher doses are used.

Nursing Mothers: It is not known whether PERCOCET is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when PERCOCET is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus. At higher doses, oxycodone has most of the disadvantages of morphine including respiratory depression.

DRUG ABUSE AND DEPENDENCE PERCOCET (oxycodone and acetaminophen) Tablets are a Schedule II controlled substance.

Oxycodone can produce drug dependence and has the potential for being abused. (See WARNINGS.)

OVERDOSAGE Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma and thrombocytopenia may also occur.

In adults, hepatic toxicity has rarely been reported with acute overdoses of less than 10 grams and fatalities with less than 15 grams. Importantly, young children seem to be more resistant than adults to the hepatotoxic effect of an acetaminophen overdose. Despite this, the measures outlined below should be initiated in any adult or child suspected of having ingested an acetaminophen overdose.

Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Treatment: The stomach should be emptied promptly by lavage or by induction of emesis with syrup of ipecac. Patient's estimates of the quantity of a drug ingested are notoriously unreliable. Therefore, if an acetaminophen overdose is suspected, a serum acetaminophen assay should be obtained as early as possible, but no sooner than four hours following ingestion. Liver function studies should be obtained initially and repeated at 24-hour intervals.

The antidote, N-acetylcysteine, should be administered as early as possible, preferably within 16 hours of the overdose ingestion for optimal results, but in any case, within 24 hours. Following recovery, there are no residual, structural, or functional hepatic abnormalities.

Oxycodone Signs and Symptoms: Serious overdosage with oxycodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride (Narcan®) is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of naloxone hydrochloride (usual initial adult dose 0.4 mg to 2 mg) should be administered preferably by the intravenous route, and simultaneously with efforts at respiratory resuscitation (see package insert). Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET (oxycodone and acetaminophen tablets) is given orally. The usual adult dosage is one tablet every 6 hours as needed for pain.

HOW SUPPLIED PERCOCET (5 mg oxycodone hydrochloride and 325 mg acetaminophen tablets, USP), supplied as a white tablet, with one face scored and inscribed PERCOCET, and the other inscribed with DuPont name is available in:

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520 (94): Level Playing Field for Physicians' Services. Calls for the AMA to study factors working against this, and to develop strategies to remedy. *Adopted as amended.*

521 (94): Diversion of Insurance Premiums. Calls for contacting the Insurance Commissioner to review diversion from direct health care to studies, programs, and subcontractors, and for legislative involvement. *Adopted as amended.*

522 (94): Patient Access to Specialty Care in Managed Care Systems. Calls for policy in favor of patients' right to self-refer to a specialist for follow-up care. *Adopted as amended.*

523 (94): Mammograms. Calls for recommendation of reimbursement for annual mammograms for women covered by Medicaid. *Adopted as amended.*

524 (94): Insurance Forms. *Re-referred to the Reference Committee on Legislation, Regulation, and Professional Liability as Resolution 405 (94).*

525 (94): Patient Charts. *Re-referred to the Reference Committee on Legislation, Regulation, and Professional Liability as Resolution 406 (94).*

526 (94): Interference with Patient Care. Calls for a Society study of cases in which insurance companies have interfered with patient care, and release of this study to state insurance commissioner. *Referred to the board for further study.*

529 (94): Physician-Owned HMO/Insurance Company. Calls for Society to endorse a Pennsylvania physician-owned health care delivery system. *Substitute resolution adopted as amended.*

531 (94): Statewide Physician-Owned/Managed PPO. Calls for feasibility study of developing a statewide, physician-owned, physician-directed PPO. *Adopted substitute Resolution 529 (94) in lieu of this resolution.*

532 (94): Automatic Processing of Major Medical Claims. Calls for Society to seek legislation to mandate automatic processing of all Major Medical claims. *Adopted.*

Membership/Reports of Officers

601 (94): Presentation of Society's Priorities as Free-standing Item of Business. Calls for presentation of the Society's proposed priorities to the House each year for approval. *Adopted as amended.*

602 (94): Membership Transfers. Calls for pro-rated transfer of county dues when a physician relocates. *Not adopted.*

603 (94): Prohibiting Medical Organization Discrimination on the Basis of Sexual Orientation. Calls for a resolution to repeal the AMA's recently adopted policy of nondiscrimination, on the grounds that the State Society has never discriminated against homosexuals and lesbians for membership, and that the term "sexual orientation" can linguistically include such behaviors as rape and pedophilia. *Not adopted.*

The nature of the reports and resoultions considered at the State Society's annual business meeting in Hershey in October reflected the complexity of the issues facing physicians practicing in the 1990s. Debated were the future of the profession and how best to prepare for it, how best to focus public health efforts to benefit patients, and what the Society must do to remain viable into the twenty-first century.

604 (94): Antitrust and Discrimination Litigation. Calls for provision of legal and financial support to Society members, and for reimbursement of the Society, with interest, when litigant is successful. *Not adopted.*

605 (94): Annual Reports from Nominees/Appointees to Health-Related Organizations. Calls for reports to the House emphasizing issues of relevance to physicians and patients. *Not adopted.*

606 (94): Fiscal Note. Calls for fiscal note to be developed by resolution author, staff, and those who must implement resolution. *Not adopted.*

607 (94): Conflict of Interest. Calls for adoption of policy requiring physicians who help develop Society policies to disclose such potential conflicts. *Not adopted.*

608 (94): Maximizing Integration of the Policies Adopted by Organized Medicine. Calls for routine comparison of AMA policies with those of its Interspecialty Section. *Not adopted.*

609 (94): Physicians' Health Programs. Calls for reaffirmation of Society's commitment to and support of this program. *Adopted.*

610 (94): Publishing AMA Board of Trustees' Minutes. Calls for availability to all members upon request. *Not adopted.*

611 (94): Removing Conflict of Interest Between PMSCO Consultant and Auditor. Calls for ensuring that the independent accounting firm that audits the PennMed Member Services Company (PMSCO) also does not have a contract with PMSCO for any management consulting service. *Not adopted.*

612 (94): Sleep Medicine. Calls for the AMA to add sleep medicine to its codes for self-designation of practice specialties in the *American Medical Directory.* *Not adopted.*

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613 (94): Limiting Campaign for AMA Office. Calls for establishment of federation policy to limit campaign-related expense. *Adopted.*

614 (94): Nominations for Society and Subsidiary Positions. Calls for soliciting names from county medical societies through a standard procedure. *Adopted.*

615 (94): Restructuring the Society Board. Calls for two trustees for the First, Second, Fifth, and Thirteenth districts. *Not adopted.*

616 (94): Restructuring the Society House of Delegates. Calls for amending Society bylaws to remove provision that makes secretaries from component societies voting delegates. *Referred to the board.*

617 (94): Amending Bylaws of Society's For-Profit Subsidiaries. Would require directors to be members of the Society, nominated by county medical societies, and in active practice, and would remove age limitations. *Not adopted.*

618 (94): Dues Freeze. Calls for no 1995 dues increase and Society prioritization of activities. *Adopted.*

619 (94): Compensation of For-Profit Subsidiary Board Members. Calls for this information to be reported annually to the House. *Not adopted.*

620 (94): Mailing List Release. Calls for establishment of policy regarding Society's list or subsets of it. *Not adopted.*

621 (94): Group Dues and Representation for All Physicians. Calls for a plan to offer discounts to any identifiable group, representation of these groups at the House, and a report to the House in 1995. *Referred to the board.*

622 (94): Society Committee Composition. Calls for due proportion of representation of county medical societies, with priority given to nominations by county medical society presidents. *Not adopted.*

623 (94): Consortium for the Study of the Federation. Calls for the Society to ask the AMA to reaffirm the policy: "The House of Delegates continue to be the governing body within each entity of organized medicine." *Adopted.*

Public Health

701 (94): Cigarettes Classified as Prescription Drugs. Calls for encouraging the FDA to make this change, and to carry a similar resolution to the AMA. *Not adopted.*

702 (94): Cord Blood HIV Studies. Calls for considering a petition to the state Department of Health disallowing such studies unless identification can be made and treatment instituted. *Referred to the board.*

703 (94): Alternative Medicine. Opposes licensure of practitioners of alternative medicine, and seeks to limit reimbursement to those with currently designated acceptable degrees. *Referred to the board.*

704 (94): Violence Against Physicians. Calls for collection and reporting of threats or incidents. *Adopted as amended.*

705 (94): Tobacco—Local Legislative Process. Seeks enactment of tobacco-related ordinances on the local level. *Substitute resolution adopted.*

706 (94): Tobacco—State Legislative Process. Calls for public hearings, referenda, and lobbying disclosures. *Not adopted.*

707 (94): Tobacco—Youth. Opposes "sting" operations and calls for encouragement of PTAs to help make schools tobacco free. *Substitute resolution adopted as amended.*

708 (94): Ad Hoc Committee to Study Violence. Calls for creation of such. *Not adopted.*

709 (94): Ad Hoc Committee to Study AIDS. Calls for such to consider legislative recommendations. *Not adopted.*

Not Accepted as Business of the House

The following late resolutions were not accepted as business of the House due to their nature, duplication of effort, and/or timing.

207 (94): Continuing Medical Education Standards. Calls for Society involvement in setting, implementation, and endorsement of some state educational standards.

527 (94): Any Willing Provider. Calls for the Society to reaffirm AMA policy on the any willing provider issue.

528 (94): Vertical Divestiture. Calls for the Society to re-refer 1993 resolutions on this issue to the board for further study.

530 (94): Any Willing Provider. Calls for Society to seek legislation to prevent denial of physicians into health care plans without reasonable cause.

624 (94): Mailing List Release. Calls for modification of the Society's existing Data Release Policy.

House Proceedings Available to Members

A bylaws change approved by the House in 1993 calls for the State Society to publish a summary of the House proceedings in the December issue of PENNSYLVANIA MEDICINE, *rather than print the entire official proceedings in the January issue, as done in the past.*

Delegates and county medical societies will receive copies of the full proceedings. Members who would like a copy should contact their county societies or call the State Society at (800) 228-7823 or (717) 558-7750, extension 406.

SUPREME COURT RULING EASES ACT 6 RED TAPE

Health care providers and their patients will benefit from a Pennsylvania Supreme Court ruling regarding adverse utilization review under Act 6 of 1990, automobile insurance reform.

The August 4 ruling allows patients and physicians to file suit immediately after receiving a negative initial PRO (peer review organization) decision—without seeking reconsideration. The ruling invalidates the Insurance Department regulation which allows litigation only after PRO reconsideration. According to the court, the regulation was inconsistent with the legislature's intent.

The case

In the case of *Terminato v. Pennsylvania National Insurance Company,* Ms. Terminato sued the insurance company, which determined that her medical treatment for injuries from an auto accident were "not medically necessary" and her care related to the injuries was "not causally related to the motor vehicle accident."

Her case was dismissed, and the Superior Court upheld the decision, saying that Terminato "did not exhaust the 'administrative' remedy by seeking reconsideration to the PRO that denied the care." However, the Pennsylvania Supreme Court reversed the decision and reinstated the case, citing:

1) that the doctrine of exhaustion of administrative remedies has no application to the peer review procedure under Act 6, since a PRO is not an administrative agency, not a court of record, and not an authorized arbitration tribunal;

2) the absence of neutrality and bias inherent to PROs; and

3) that PRO reconsideration under Act 6 is a permissive remedy, rather than a mandatory and exclusive remedy.

The court concluded that because the regulations do not provide a remedy for the non-payment of medical benefits, and because PRO reconsideration is a cost-containment measure to assist insurance companies and is not an alternative dispute resolution procedure, the remedy is inadequate and does not require exhaustion prior to filing litigation in a court of competent jurisdiction.

Ruling benefits physicians, patients

The Supreme Court decision in this case benefits patients and physicians in two ways. First, auto insurance regulations permit insurers to select the URO for initial review and use the same URO (albeit a different reviewer) for reconsideration. The court's decision benefits patients and physicians by bypassing the reconsideration step. Second, reconsideration proceedings require time and can be quite costly to the physician. The decision, again by bypassing reconsideration, thus saves time and money.

For additional information on this ruling or Act 6 in general, call the Society's Department of Regulatory Affairs and Specialty Legislation at (800) 228-7823 or (717) 558-7750.

Portions of this article are excerpted with permission from Health Law Digest *of the National Health Lawyers Association, vol. 22, no. 10, page 81.*

LEGISLATIVE ELECTION RESULTS MIXED

As the victories of Republicans **Tom Ridge** and **Rick Santorum** came into focus, the rest of the election results from congressional and state legislative seats could most appropriately be described as "mixed" when examined from a partisan view.

The dichotomy lies in the fact that Senate Republicans were able to increase their majority to at least a 29-21 count, while the House remained temporarily under control of the Democrats. The unofficial results show a 102-101 Democratic margin in the House, although reports indicated that another party switch was imminent.

In Congressional races, Republicans have the potential for a net gain of one. They would then take control of the state delegation 11-10. Of course, the strength of the delegation is enhanced by the Santorum victory in the U.S. Senate race and the re-election of Arlen Specter two years ago.

As is the case, however, with one state Senate seat and one state House seat, the margin between the candidates in the 15th District is so close that a re-count will be needed to decide the winner. The incumbent, Paul McHale, is a Lehigh County Democrat. The challenger is Jim Yeager.

State Senate Republicans built their 29-21 majority by winning three of the four "open" seats and holding their likely loss to the heavily contested Marks/Tartaglione race in the 2nd District. As a bonus, they were able to trade a probable Marks loss for a strong win by challenger **Dan Delp** in the 28th District (York). Delp defeated incumbent Mike Bortner by polling 57 percent of the vote in the upset.

The three Republican winners in the open seats were all "takeovers" that brought new seats into the Republican caucus. Those three winners were **Joe Uliana** in the Reibman seat (Northampton County), **Jim Gerlach** in the Pecora seat (Chester County), and **Tommy Tomlinson** in the Lewis seat (Bucks County). Uliana overcame a 15,000 registration deficit to win by almost 1,000 votes. Tomlinson also faced a registration deficit.

The only Democratic wins in open seats were turned in by **Rich Kasunic** in Fayette County and **Vince Hughes** in Philadelphia. Kasunic replaces fellow Democrat Bill Lincoln. Hughes won the special election to replace Democratic congressional candidate Fattah.

Uliana, Gerlach, Tomlinson, Hughes, and Kasunic are all veteran House members who made the jump to the Senate. They and Marks all had the support of the Pennsylvania Medical Political Action Committee (PAMPAC). If Marks retains his seat after the expected re-count and court challenges, the Republican majority would be 30-20.

State House results showed very little change. Although each party won an open seat that had been in the hands of the opposition, the Democrats were also able to defeat an incumbent Republican. The most interesting development was the unresolved race in Northampton County.

In the open seats, Republican **Pat Browne** won his bid to replace retiring Karen Ritter (Lehigh County). Meanwhile Democrat **Lisa Boscola** took the seat formerly held by Uliana (Northampton County). The Democrats built on their majority by defeating incumbent Ralph Acosta with newcomer **Ben Ramos** (Philadelphia). After losing the primary election as a Democrat, Acosta had changed parties and joined the Republican caucus.

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Both parties claimed a win in the Northampton County seat held by incumbent Frank Yandrisevits, a Democrat. He was challenged by Julie Harhart. As a result the Democratic majority is at least 102-101, and it could become 103-100.

House Republicans were unable to score victories in the legislative races where they sent strong challengers against incumbents thought to be vulnerable. In the balance of the open seats, each party held its own. It is expected that both House caucuses will have closely contested leadership elections behind closed doors.

There was a guarantee of change in our **Congressional** delegation as a result of the decisions by Tom Ridge and Rick Santorum to leave the U.S. House and seek other offices, the retirement of Austin Murphy, and the primary defeat of Lucien Blackwell.

Candidates supported by AMPAC/PAMPAC were winners in three of the four open seats and in two of the elections in which first-term incumbents were defeated.
In Philadelphia, **Chaka Fattah** (D) won his bid to succeed Blackwell after defeating the incumbent in the primary. Other first-time Democratic winners were **Frank Mascara** (Washington County) and **Mike Doyle** (Allegheny County). Doyle replaced Santorum, and Mascara replaced Murphy.

The Republicans had one "takeover" win as **Jon Fox** (Montgomery County) beat Marjorie Mezvinsky. As noted above, the McHale-Yeager race is "too close to call." Both McHale and Mezvinsky were serving their first terms.

Finally, in another close race, Republican **Rick Santorum** defeated incumbent Harris Wofford for a U.S. Senate seat. The defeat of the first-term senator came in one of the pivotal races that was monitored nationwide.

The author, Andrew W. Gurman, MD, an Altoona orthopedic surgeon, is chairman of PAMPAC.

HEALTH SYSTEM REFORM

ONE HUNDRED DAYS AND COUNTING

While it's hard to believe that more than two years have passed since President Clinton promised health system reform legislation "in the first 100 days," the debate on reform seems to have lasted 100 years. Let's take a few minutes to reflect back on that debate, and look ahead to what's anticipated for 1995.

Reflecting back

It was in 1993 that Hillary Rodham Clinton, Ira Magaziner, and a small group of "experts" took on the task of developing reform legislation. But, what was thought possible in 100 days quickly became more complicated than anticipated. Mrs. Clinton became the target of intense criticism, and the issues became the center of a rope being "tugged" in both directions.

The initial presentation of the Clinton plan to Americans was pushed off from spring until early summer, from early summer until late summer, and finally, from late summer to early fall. When the infamous "health security card" speech made it to the airwaves in October 1993, President Clinton called for universal coverage, employer mandates, health alliances, and portability, just to name a few initiatives—and proposal of legislation was again pushed off, this time to the summer of 1994.

As the new year rang in, health care remained one of the president's top three issues. But within three months of presenting his non-negotiable reform package, President Clinton was ready to compromise with Congress, as long as he could still assure coverage for every American through an employer mandate. That action triggered proposal of a number of reform bills in Congress, each seeking a different resolve—whether it be universal coverage, a single-payer system, employer sponsorship, tax breaks, or minor adjustments to the current system.

Likewise, on the state level, Governor Casey's '94 agenda included health system reform and a call for passage of legislation to "overhaul" the system. But a shift in Senate majority early in the year decreased the chances of the General Assembly passing any reform legislation in 1994.

The issue was quickly cooling in Harrisburg; the gubernatorial primary election and budget negotiations overshadowed all reform efforts. In a public statement in May, Governor Casey criticized the legislature for ignoring the health system reform issue.

By late summer, though the Clintons continued to travel in support of their plan, it was evident that reform legislation would not be passed in 1994. The official "death certificate" came in late September from Senator George Mitchell.

Looking ahead

With reform dead at the national level, all eyes are on the state level. Though in Pennsylvania the debate never really began, the commonwealth has been recognized nationally for some innovative efforts, including: the Children's Health Insurance Program, funded by a two-cent-per-pack cigarette tax; implementation of managed care programs to better handle Medical Assistance patients; and the establishment of the Pennsylvania Health Care Cost Containment Council in 1986 to evaluate physicians and hospitals.

But all roads seem to lead back to Washington, where President Clinton has promised new legislation next year, one issue at a time, and all major players in the national debate have vowed to return to the issue quickly in 1995.

Among the president's goals for the new plan are a reduction in the growth of health care costs and an expansion of coverage through Medicaid and voluntary insurance pools. Funding is proposed through Medicare cuts and sin taxes; his non-negotiable issues of universal coverage and employer mandate are expected to be absent from the plan.

FILIBUSTER ENSURES FREEDOM OF SPEECH

A filibuster in Congress will allow individuals and associations, such as the State Society and the AMA, to continue practicing freedom of speech before Congress without being hampered by fines and taxes.

The proposed Lobbying Disclosure Act of 1993 would have limited grassroots activities of special-interest groups. The federation of medicine opposed the legislation, which proposed "onerous reporting requirements" and "would create another bureaucracy." The federation also maintains that such an act "may have a chilling effect on free speech and will make it more difficult for American citizens to have their voices heard in Washington."

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How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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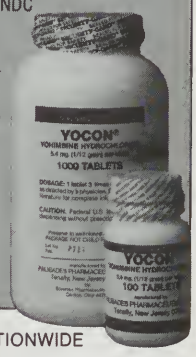

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While many of the past winners of the Pennsylvania Medical Society's Distinguished Service Award were honored for their pioneering and technological advances, Robert W. Ford, MD, of Allison Park, the most recent recipient of the award, was recognized for his respect of tradition: Daily, he lives the Hippocratic Oath.

1994 Distinguished Service Award:

Living the Oath

Maria T. Montesano
Assistant Managing Editor

After 20 years in medicine, a physician may find himself wanting to do more with his life. And one day, on his way out of his office, he may stop to re-read the Hippocratic Oath, which has been hanging on the wall, yet has gone unnoticed for years. And on that day, the flame will ignite. At least, that's what happened to Robert W. Ford, MD. And so the changes began—for himself, his colleagues, and the people of a remote area of Nigeria.

Dr. Ford this year became the sixteenth recipient of the State Society's Distinguished Service Award. Among the past recipients are Dr. Jonas Salk, Dr. Thomas Starzl, Dr. Lewis Bluemle, and in 1993, Dr. George Magovern Sr.

At its annual business meeting in October, the Society awarded Dr. Ford the distinguished service medallion "in recognition of his meritorious service in the art and science of medicine and for his World Health Mission work which reflects great credit on the profession."

Dr. Ford accepted the medallion and recognition humbly, with a tear in his eye. "What I've done is just a little thing, something that just has come naturally for me," he says. "I wake up, and it's part of me." He views the past recipients of this award as "giants in medicine," contributing in ways that have benefited mankind technically. "I have made a different contribution to life, making it better in different ways. Hopefully, I've touched more people than I've ever realized."

A man of heart

Dr. Ford, a native of Pittsburgh, decided in high school to pursue a medical career. After receiving a bachelor's degree in chemistry from Franklin and Marshall College, Lancaster, he attended Temple University School of Medicine, Philadelphia, earning his medical degree in 1963. He then moved west, to complete an internship and residency at Presbyterian Hospital, Denver, Colorado.

Two things happened to Dr. Ford in Colorado. First, though he had gone there to become a family physician, he quickly recognized that the specialty of obstetrics and gynecology was where he belonged. "It was a natural field for me," Dr. Ford says. "It was a little bit of surgery, a little bit of medicine, and a little bit of consulting with patients about their health and personal problems." To this day, the one-on-one with patients, and getting their health "on the right track," are what he enjoys most in the office. But, he adds, "Delivering babies is pretty exciting, too."

The second milestone of his life in Colorado was meeting his future wife, Karen, who is quite involved in her husband's humanitarian efforts. "I'm glad I met the woman I met, and married her 27 years ago," Dr. Ford says. "She was a school teacher in Denver, I was from Pittsburgh, and we just hit it off. We've had a nice life...a good life. I was lucky."

The Fords returned to Pittsburgh in 1967, where Dr. Ford has been in private practice ever since. He is also chairman of the Department of Obstetrics and Gynecology at North Hills Passavant Hospital, a position he assumed in 1988. His

professional activities include serving as a member of the hospital's executive committee, chairman of Pennsylvania Blue Shield's Board of Directors Medical Review Committee, and in recent years he has been an active member of organized medicine at both the county and state levels. He and his wife are the parents of two boys.

Yet, there is more to Dr. Ford than meets the eye. In talking with him, you notice instantly that his manner is quiet, his tone calm; and he exudes a "goodness" that lingers with you long after your conversation ends. You are left knowing you, too, can be a better person—patient and caring and purposeful, comforting, and, yes, humble. These qualities are a reflection of the satisfaction Dr. Ford has found since that one day in his office, the satisfaction in working with the World Health Mission.

A mission of hope

Dr. Ford established the World Health Mission in 1988 with the help of Dr. Olu Sangodeyi, chief of surgery at North Hills Passavant Hospital and a native of Nigeria. The basic philosophy of the program when it started, Dr. Ford says, was "to serve and work for the betterment of some part of the world."

"In November 1991, six of us stepped off the airplane in Nigeria in the dark, not knowing anybody or anything. We didn't know what we were getting into. We drove four hours into the desert, to a hospital in a town of 200,000 people." The hospital is Jos University Hospital, Jos, Nigeria, Africa.

He says that, initially, the focus of the program was more personal, developing the obstetrics and gynecology operations. But that has changed over time. "I have developed more of an interest now in the hospital as a global project," Dr. Ford says. "What I've tried to do over the last few years is seek out areas in the hospital that need assistance. I ask, 'What do you need? What can we do for you? Is there anything I can help you with?' "

Upon returning to the U.S., he begins work to fill those needs. For instance, he is currently focusing efforts on further developing the hospital's existing neonatology unit.

But he says preparing for each trip also is quite complicated and time-consuming, requiring about six months. There is equipment to transport to Nigeria, physicians and technicians to recruit for the journey, educational materials to gather, and "red tape." "You have to prepare, you have to pack, you have to get things, you have to pay for all the equipment that has to be taken over, you have to get professionals to run the equipment, you have to make sure the machines work." Dr. Ford credits his wife for taking a lead role in the preparation for each trip.

Currently, the Fords are preparing for a trip next month. An ultrasound expert, a pathologist, a urology professor, a maxillo-facial surgeon, an otolaryngologist, and two anesthesiologists will lend their expertise, and Dr. Ford will be helping resident physicians use a colposcope for cancer screening. They will work continually during their 18-day stay, and the Fords will visit another Nigerian hospital to see what the mission might be able to contribute there in the future. Funding for the trip comes from the participating physicians, church or hospital sponsorships, grants, and donations to the mission.

Dr. Ford admits that while the mission "doesn't consume my every minute, sometime during each day, I think about it." Amidst practicing medicine and preparing for the January trip, he continues to work on other requests that come to the mission. Currently, he has requests for a card file to help the Jos hospital organize its patient admissions, for hepatitis testing kits, for surgical gloves, and even for a dentist to travel to Nigeria with him in the future.

"In spite of all of the turmoil and travail, for many of us, that oath still lives."

Dr. Ford

As for the long-term future, Dr. Ford isn't sure what will happen with the mission. But he does say that, no matter what occurs, "The people in Jos will never forget us, and we'll never forget them. We've been able to contribute exactly what they've needed...and they've made us better for it. I can sit down now with Nigerians, and I look at them as personal friends and professional colleagues. I have a very warm spot in my heart for that relationship...Though material things and politics and religion sometimes complicate the process, working together is really the key."

An example for all

Still, in the end, it all comes down to the Hippocratic Oath, Dr. Ford says. "It's so easy in medicine today to get lost in pressures of third parties and liability, and the demands and the restraints. That's what I discovered in the mid-'80s: I was getting involved in a lot of that and getting away from the real oath."

"I truly believe the Society should be commended for still recognizing holders of the oath," he adds. "In spite of all of the turmoil and travail, for many of us, that oath still lives."

He would advise all physicians to go back and re-read the oath. "Just think about it and where you are in life. Are you really going in the direction you want to go? At one time I wasn't, but I feel now, when I look at the Hippocratic Oath, that I live it."

As his county society stated in his nomination, "Surely Dr. Ford's efforts set an example for all physicians." ⬡

Dr. Ford and the World Health Mission were featured in the May 1994 issue of PENNSYLVANIA MEDICINE (pages 32-33). For more information about the mission, call Karen Ford at (412) 487-6611.

Poised for Tomorrow: An Inside Look at The Educational and Scientific Trust

Matthew Tornambe

"Where there is a love of man, there is a love of medicine."

Hippocrates

These words by the father of medicine aptly describe the philosophy of The Educational and Scientific Trust of the Pennsylvania Medical Society. Since 1954, the Trust has worked to benefit both man and medicine through its philanthropic activities. Although the Trust's philosophy has not changed over the years, its focus has. It has evolved from being known primarily for the medical student loan program, to the organization it is today—which includes seven major program areas, assets of $8 million, an annual $1.5 million budget, and a staff of 17.

Physicians have always understood the value of philanthropy. It occurs when people see a need and respond to effect change. As the Trust looks to the future, it will be joining forces with others who share its values to tackle critical issues facing medicine and the citizens of the commonwealth. For 1995, the Trust has aimed its sights high and set the following goals:

- establish a coalition of health professionals, public health advocates, government officials, and corporate leaders to jointly address Pennsylvania's public health priorities;
- equip physicians to adopt a leadership role in responding to changes in today's health care marketplace;
- build a network of former Physicians' Health Programs (PHP) participants across the state to assist PHP staff with program activities on the local level;
- enhance the Trust's loan programs to more effectively provide medical and allied health students with financial support to complete their education; and
- encourage more physicians to contribute their time and money to supporting the Trust's programs.

Mr. Tornambe became executive director of the State Society's Educational and Scientific Trust in February 1994.

Public health needs

The Trust was originally established as a nonprofit, charitable organization to address public health needs on behalf of physicians in Pennsylvania. In 1992, it created Keystones of Public Health in an effort to return to that original mission. Further expansion of this project will be a Trust priority in 1995.

Often, groups working in public health have not included all the players—physicians, hospital administrators, government officials, representatives of public health organizations, and corporate leaders—in addressing issues. Unfortunately, in the past, many of these groups never talked to each other, or worse yet, refused to work collaboratively.

The Trust's goal with this program is to pull together these interested groups to jointly identify and address Pennsylvania's most critical public health needs. The contention is that solutions are more effectively defined and implemented when all the stakeholders, particularly those closest to the issue, participate.

The Trust believes that, ultimately, good public health will be obtained only when there are no incidences of preventable diseases or injuries and when individual members of society can expect to maintain high levels of personal health. This may seem a lofty goal, but it is attainable by changing unhealthy behaviors. The Keystones of Public Health coalition will target some of these behaviors in its educational activities during the coming year.

Physician leadership

Another Trust priority for the coming year will be expansion of the Institute for Physician Leadership. The institute trains physicians to be dynamic leaders of their institutions and professional organizations; its focus for 1995 is the emerging physician leaders in the new health organizations—such as physician organizations (POs), physician-hospital organizations (PHOs), and other vertically integrated physician entities—that are being created by the changing medical marketplace.

Physicians in these new corporate structures often are not involved in their state or county medical society, or part of

the hospital medical staff leadership. However, these physicians will become increasingly important in shaping the health care environment. Programs such as "Cost-Effective Clinical Decision Making," "Leadership Style Assessment," and "Consensus Development" are now among the institute's educational offerings. The institute has also been working very closely with the PennMed Member Services Company (PMSCO), the State Society's consulting company, to jointly address the needs of this new physician group.

Physician health

PHP has been a thriving component of the Trust's services and will continue to grow during the coming year. PHP offers advocacy and support to physicians experiencing impairment from physical, emotional, or mental conditions. Drug and/or alcohol abuse is the primary cause of impairment with which the PHP deals.

Currently, all PHP activity is centralized in Harrisburg. In 1995, the program will focus on developing a network of physicians across the state who will work locally with colleagues with impairment. Former program participants will be recruited to join the network.

In November, for example, the Trust brought former PHP participants together at a dinner in Hershey. This highly successful event enabled these physicians to talk to others who experienced similar problems. It also gave the Trust the opportunity to show the physicians how they can give back to the program, both financially and by volunteering to assist PHP staff at the local level.

PHP sees the need for its services increasing in years to come due to earlier identification and referral of professionals with impairment. Presently, its community outreach is conducted primarily through hospital medical staffs.

Because physicians in the future will be more involved in organizations outside the hospital structure, it is important that PHP's reach extends to all the different entities where physicians will be working, to deliver services and encourage early referrals. By creating this voluntary network of local physicians, the program will be able to adapt to the changing health care structure and the needs of physicians.

Aid to students

The most well-known Trust service is its student loan program. It has provided almost $10 million in financial assistance to more than 3,200 medical and allied health students. This crucial activity makes a significant difference in the lives of many struggling students.

To enable the loan program to meet the evolving needs of students in the '90s and beyond, the Trust will be conducting a full-scale marketing study on this program in 1995. The Trust has been operating under policies and guidelines that were developed many years ago. The environment has changed, the needs have changed, and so has medical education.

Through this marketing study, Trust staff members will be talking to students, former loan participants, and financial personnel at the state's medical schools to determine how the loan program can better meet the needs of each group. By 1996, the Trust will be able to implement changes, making the program more attractive to Pennsylvania's medical and allied health students.

A call for help

The most important challenge for the Trust in 1995 is to get more Pennsylvania physicians involved in its programs and activities. To build its services and attract the financial support needed to attain the goals just outlined, the Trust needs physician volunteers to serve on program committees and in leadership positions.

During the coming year, the Trust will use its marketing skills to identify physicians who are involved in or show interest in the various Trust program areas—public health, student loans, physicians with impairment, and physician leadership. These physicians will be personally asked to volunteer their time and expertise to help the Trust meet its future challenges. The Trust will also expand its fundraising activities and conduct several aggressive, innovative campaigns in 1995 to increase its financial resources.

Why should you give your time and/or money to the Trust? Abram Hostetter, MD, chairman of the Trust's board of trustees, recently pointed out some personal benefits physicians receive from giving: "I think contributing to the Trust makes a person feel good about himself or herself. You are giving to a charity that is specifically identified with medicine, and which does a specific good for the next generation of physicians and the public. By supporting the Trust, you gain the satisfaction of knowing your gift makes a difference. You also become part of an organization that serves and will continue to serve not only the medical profession, but society as a whole."

Want To Help?

Physicians have many opportunities to become involved in the programs and activities of The Educational and Scientific Trust. The Trust is always looking for physicians to serve on program committees or to volunteer for a specific project. For example, a physician may choose to work in a designated program area, such as Keystones of Public Health or the Institute for Physician Leadership, or he or she may wish to help for a limited time on a specific activity, such as Trust fundraising.

You can always help by making a gift. When doing this, you may indicate that your contribution be used for a specific program or project, such as the Physicians' Health Programs or the student loan program. Send your tax-deductible donation to: The Educational and Scientific Trust, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

For more information about any of the Trust's programs or services, or if you want to volunteer to help, call us at (800) 228-7823.

Treating HIV in Pennsylvania

Maureen Hoepfer

John J. Dennehy, MD, FACP, is emeritus director of the Department of Infectious Diseases at Geisinger Medical Center, Danville. Since the mid-1980s, he has been involved with the treatment of and the political issues surrounding HIV infection. Currently, HIV-infected patients comprise 80 percent of his outpatient practice.

Since the first report of AIDS was published in the June 5, 1981, issue of *Morbidity and Mortality Weekly Report*, the United States has come a long way in managing the medical and political issues presented by this deadly disease, says John J. Dennehy, MD. However, he adds that the HIV epidemic is getting worse, and he does not see a cure on the horizon.

"To date, there have been more than 360,000 cases of AIDS reported in the United States. Pennsylvania alone has had almost 12,000 cases," Dr. Dennehy says. "The sad part is, overall, more than 60 percent of these patients have died."

Statistics from the Centers for Disease Control and Prevention show some disturbing trends in the progression of the disease, according to Dr. Dennehy:

- HIV infection has become the most common cause of death for men between the ages of 25 and 45 in the Unites States.
- Heterosexual women make up the most rapidly growing population group acquiring new cases of HIV infection. Currently, HIV is the fourth most common cause of death among women.
- The HIV-infection rates among teenagers and the number of babies born to HIV-infected mothers are increasing exponentially.

"Despite all the reports in the media about HIV infection, most people still live with their heads in the sand," says Dr. Dennehy. "Their attitude is, 'HIV will never affect me or my family.' Unfortunately, as the numbers increase, more and more of us will be touched by the disease."

Dr. Dennehy

Progress in HIV management

Dr. Dennehy says medicine has made significant progress in dealing with HIV. He points out that in the past decade, medicine has discovered the cause of the disease, developed tests to diagnose HIV infection, and has significantly improved the prevention and treatment of some of the complications of AIDS.

"We're learning slowly, but we now have more and more new [antiviral] drugs available to help prevent and treat many of the problems brought on by HIV infection. These can vastly improve a patient's quality of life," he explains.

Social service personnel and public health officials have also contributed to improving the lives of HIV-infected patients. For example, the increase in hospice facilities and home health care enables patients to convalesce and die in more humane settings. HIV support groups help patients and families more effectively cope with the trauma associated with the disease.

"We've also made tremendous strides in educating the public about HIV infection," he adds. "Although there is still fear out there, you don't see the hysteria among people that you did when the disease was first made public in the '80s."

Although Dr. Dennehy believes there has not been enough political activity to deal with the HIV problem, he cites some progress. HIV-infected patients now have some protection under anti-discrimination laws. As an example, he points to the Americans with Disabilities Act which prohibits

Ms. Hoepfer is a marketing associate for the Society's Educational and Scientific Trust. This article is one in a series, begun in January 1993 and ongoing through 1994, sponsored by the Trust's endeavor to address public health needs, Keystones of Public Health.

employers from discriminating against an employee because of a handicap such as HIV infection.

In Pennsylvania, Act 148, the AIDS Confidentiality Law, safeguards all medical information related to an AIDS or HIV-infected patient. Funding for HIV research and education has also increased in recent years, but it is still not enough, he adds.

Flaws in the system

Despite this progress, Dr. Dennehy says there are still many flaws in the systems developed to handle the disease. In Pennsylvania, for example, physicians are not required to report cases of HIV infection to the Department of Health—they are only required to report full-blown AIDS cases. He sees this as a major deficiency.

"Making HIV infection reportable would allow the Department of Health to conduct contact tracing," he explains. "This means the Department of Health would attempt to track down and notify the sexual partners of HIV-infected patients and advise them to get tested."

Contact tracing would enable the department to better track the progression of the disease in the state and allow for earlier detection. "Early HIV detection can prevent the unwitting spread of the virus by an infected patient, ease an infected person's decline, and even save an HIV-positive pregnant woman's unborn child," Dr. Dennehy says. He adds that the Pennsylvania Medical Society has supported attempts to make HIV infection a reportable disease—which is currently the case in 26 states—and advocates contact tracing.

Protecting health care workers

During the past year, Dr. Dennehy, as chairman of the Society's Commission on Public Health, was involved in the development and review of the Pennsylvania Department of Health's "Guidelines for Preventing the Transmission of Human Immunodeficiency Virus and Hepatitis B Virus from Infected Workers to Patients." He was successful in negotiating several major changes in the guidelines which protect the interests of health care workers.

In the original draft, for example, a hospital or health care facility was given primary responsibility for determining when patients should be notified about an HIV-infected health care worker. However, the final guidelines transfer that responsibility to the Department of Health after consultation with the infected worker's personal physician(s).

Dr. Dennehy has also played an instrumental role in educating health care providers, legal professionals, and the public about a wide range of issues surrounding HIV infection. Over the past 10 years, he has given numerous presentations to school groups, lawyers, residents, legislators, and community groups such as Kiwanis and Rotary clubs. While a member of the Society's Task Force on AIDS, he also served as a main reviewer for the Society's "AIDS Information for Physicians," an educational booklet sent to every State Society member several years ago.

Caring for HIV-infected patients

Dr. Dennehy encourages physicians to accept HIV-infected individuals as patients. He explains that most of these patients can be followed by primary care providers who can request infectious disease consultation as needed. "Early on, most HIV-infected patients are asymptomatic and don't need expensive medications. Primarily, all they need are follow-up tests," he explains.

He emphasizes that caring for HIV patients demands a team approach, involving social services, nursing, and family support. "A physician cannot do everything," he says. In managing HIV-infected patients, Dr. Dennehy advises physicians to keep current on treatment advances.

Despite his numerous community activities and work with the Society, Dr. Dennehy says his first allegiance is to his patients. "I'm not an ethicist, lawmaker, administrator, or social worker. I'm simply a physician who cares for HIV-infected patients," he explains. "I've seen the advances we've made in treating these patients and improving the quality of their lives, but too many of them continue to die," he says. "Every patient I lose still breaks my heart. We have a lot of work ahead of us." ⬡

"Making HIV infection reportable would allow the Department of Health to conduct contact tracing."

— John J. Dennehy, MD

Resource for HIV-Infected Physicians

HIV-infected physicians may call the Physicians' Health Programs (PHP) of the Pennsylvania Medical Society's Educational and Scientific Trust at (800) 228-7823 for *confidential* information, referral, and support services. After work hours (8:00 a.m.-5:00 p.m., Monday through Friday), call the PHP's message line at (717) 558-7817, and a staff member will promptly return your call.

Financial Planning in an Age of Managed Care

Robert L. Lamb

While much is written about the effect of managed care on clinical medicine, less has been said about its impact on physician family financial planning.

If managed care is a euphemism for "rationing of clinical resources," the same is true for "physician income." There are few signs of rising income for physicians, hence prudent management of physician family finances is the order of the day.

In an environment of managed physician incomes, how shall medical families maintain their lifestyle, finance their children's education, and still provide for future illness and retirement? Certainly, procrastination is not the answer. An immediate, proactive approach to financial planning is required.

Financial challenges facing physician families include premature death, prolonged life, emergencies, or mental or physical disability. Several tools are needed to address these challenges:

- the will as the cornerstone,
- placing property in trust,
- powers of attorney,
- joint ownership,
- living wills,
- the charitable dimension,
- income and asset management, and
- tax advantages.

For families in their 20s-30s

Be certain that you have adequate life insurance. Understand that insurance protection is different than savings. Life insurance policies which offer savings benefits are a mixed bag and may not be as an efficient use of your money as, for example, would be term insurance.

Begin a retirement program *today*. Ask your financial adviser to run some spread sheets on the effects of inflation over time. This will help you set aside a more appropriate amount.

For families in their 40s-50s

Leave retirement money alone. College bills loom and that vacation house is so attractive, but raiding the retirement funds is not the answer. Success in medical practice sometimes gives the illusion that clinical prowess carries over into business affairs. The temptation to invest in high-yield, risky ventures grows. Resist.

By all means find a financial adviser with a proven track record who is not connected to a product. The odds are that the wisdom of several minds working on your retirement and estate questions will produce a better solution.

Take another look at your auto and home liability policies. Now that you have net worth, you must be certain that it is adequately protected by insurance.

Don't rely on the marital deduction to solve your estate-planning problem. Leaving all your assets to your spouse simply increases the estate tax at the time of that person's death. A better solution is to set up a trust—either in your will or a separate document—to support your family until your spouse's death, when the remaining assets will be paid out to your designated beneficiaries.

For families in their 60s-70s

Make sure your wills are up to date. This is the time of life when events speed up. Grandchildren are born, children divorce, members of the extended family die. Even one year can bring many changes to your family.

Do not allow an excess to accumulate in your qualified plan. Work with your accountant and financial planner to be sure that at the appropriate age, you begin taking out the correct amount from your qualified retirement plan. Take out too much, and you may have to pay an excess distributions tax. Take out too little, and you may have to pay an excise tax for failure to receive the required minimum distribution, and your estate may have to pay an excess accumulations tax.

Don't let your antipathy for lawyers and things legal lead you to create your own simple solution to a complex problem, such as creating joint accounts with your children or grandchildren. The double whammy of federal estate and generation-skipping transfer taxes on such joint ac-

Mr. Lamb is planned giving officer of the Society's Educational and Scientific Trust.

counts will deprive the surviving joint owner of a significant amount of the balance in the account.

Sign durable powers of attorney and living wills.

Keep some money in stocks. In retirement, many families move most of their money out of the stock market into fixed income investments. But inflation is no respecter of age. A hedge against inflation is still necessary.

Check out the total tax structure in retirement communities before making a move. Low state income taxes could mean high sales taxes.

Remember the IRS annual $10,000 gift tax exclusion. You can reduce the size of your estate by gifting up to $10,000 per person per year.

Check the beneficiaries on instruments related to your estate, such as insurance policies, retirement plans, bank and brokerage accounts. Life is a series of changes, and you may be surprised by some of the names on those instruments.

Philanthropic contributions

Consider making a philanthropic statement. Now is the time to think about what you will leave behind when you join that big group practice in the sky. Medical families with a charitable intent can assure that their concern for others is continued long after they leave by making tax-deductible contributions to institutions such as The Educational and Scientific Trust.

Many physicians, when they analyze the core values around which they have built their lives, find that *education* stands out. In many ways, education is a synonym for medicine. That's why the charitable work of the Trust with medical students resonates with so many physicians.

The most frequent philanthropic expression of physicians is a bequest to the Trust. But it is also possible to use the Trust as part of one's retirement plan through such instruments as gift annuities and charitable remainder trusts. These plans provide income for you and your spouse in retirement and subsequently constitute a meaningful gift to the Trust.

Augustus S. Kech, MD: Values and Compassion in Perpetuity

Augustus Kech became a physician and then a physician-leader by living out the principles and values he learned as a boy growing up in Snow Shoe, Pennsylvania.

A product of the public schools, with degrees from Lock Haven Teacher's College and Bucknell University, he earned his medical degree from the University of Pennsylvania in 1911. He led his peers at Mercy Hospital in Altoona, first as chief of medicine and then as chief of staff. In 1927, he became president of the Blair County Medical Society, then a trustee of the Pennsylvania Medical Society for 10 years, and finally, its president in 1943.

With a commitment to public health, he became personally involved in school immunization programs, mosquito control, water purification, TB clinics, and the Red Cross Disaster Team, to name a few. While these activities mark Dr. Kech as a truly community-minded physician, what makes him noteworthy, thirty-some years after his death, is the fact that he had the foresight to assure that his medical compassion would continue forever.

In his will, after providing for his family throughout their lifetimes, he made six-figure bequests to the Medical Benevolence Fund of the Pennsylvania Medical Society (which is managed by The Educational and Scientific Trust) and to the medical student loan program of the Trust. In so doing, Dr. Kech has assured that his values will continue to be met as he would want. All it took was the wisdom to add a few words to his will. Consequently, his caring and compassion will continue to touch lives in perpetuity.

Are you concerned about the future of medicine? ...about the future health needs of your community? Talk to us about ways the Trust can assure that your values will be advocated, even after your death.

Estate Planning for Physicians

Please send me the free pamphlet, "Why You Should Have An Estate Plan."

Name_____

Address_____

City_____ State _____ Zip_____

County _____ Telephone _____

Bob Lamb, Planned Giving Officer, The Educational and Scientific Trust,
P.O. Box 8820, Harrsburg, PA 17105-8820, (800) 228-7823

John A. Carlson Jr., MD, director of gynecologic oncology, Thomas Jefferson University Hospital, Philadelphia, has been elected to a one-year term as president of the Pennsylvania Oncologic Society.

Pittsburgh cancer surgeon **Norman Wolmark, MD,** Allegheny General Hospital, was selected by the executive board of the National Surgical Adjuvant Breast and Bowel Project (NSABP) as chairman of the nation's breast cancer research project. He replaces Bernard Fisher, MD, the Pittsburgh surgeon who was asked to step down as NSABP chairman this year after revelations of fraud and error in NSABP projects.

Dorothy Lansing, MD, Paoli, has received the Otis R. Bowen, MD, Distinguished Leadership Award from her alma mater, Indiana University School of Medicine, Indiana. Dr. Lansing practices gynecology and is the historian and archivist for the Obstetrical Society of Philadelphia.

Richard P. Moser, MD, Hummelstown, professor of radiology and **John E. Madewell, MD,** Hershey, professor and chairman of radiology, Penn State's Milton S. Hershey Medical Center, have been named fellows of the American College of Radiology.

Dr. Wiener

David H. Wiener, MD, has been promoted to the position of associate professor of medicine in the cardiology section, Temple University School of Medicine, Philadelphia.

Barbara L. Fowble, MD, Rydal, has been appointed staff radiation oncologist and associate director of the breast cancer program, Fox Chase Cancer Center, and **Gerald Hanks, MD,** chairman of radiation oncology, has been awarded the Gold Medal by the American Society for Therapeutic Radiology and Oncology. The Gold Medal is given to physicians who have made outstanding contributions to the development of therapeutic radiology and oncology. The Center has also named **David B. Sokol, MD,** as the first Berlex Laboratories Fellow in Medical Oncology and **Nava Siegelmann, MD,** the first Ortho Biotech Oncology Fellow in the Medical Oncology Department. Also, at Fox Chase, **Louis M. Weiner, MD,** Elkins Park, has been appointed chairman of the Medical Oncology Department, Division of Medical Science.

Pottsville Hospital and Warne Clinic have appointed **Carlos X. Villarreal, MD,** to a three-year appointment as cancer liaison physician for the Hospital Cancer Program. The program is an integral part of the Commission on Cancer of the American College of Surgeons.

Dr. Trooskin

The Medical College of Pennsylvania and the Hahnemann University School of Medicine, Philadelphia, have named **Stanley Z. Trooskin, MD,** director of trauma and surgical critical care for the integrated trauma program.

Warren A. Katz, MD, chairman, Department of Medicine, Presbyterian Medical Center, Philadelphia, was a speaker at the October 20 American Medical Association briefing entitled, "Pain: Evaluating and Managing What Hurts."

Michael I. Cheikin, MD, has been appointed medical director, Chestnut Hill Hospital Springfield Center, which encompasses Chestnut Hill Rehabilitation Hospital and the Springfield Residence retirement community.

Susan J. Denman, MD, Bala Cynwyd, was appointed chairman, Division of Geriatric Medicine, Albert Einstein Medical Center, Philadelphia. Dr. Denman has also be appointed medical director and senior vice president of medical affairs at the Philadelphia Geriatric Center.

Kevin R. Fox, MD, associate professor of medicine, University of Pennsylvania Medical Center, Philadelphia, was recognized for teaching excellence in oncology at the University of Pennsylvania Cancer Center.

Esther J. Nash, MD, clinical professor, Jefferson Medical College, Philadelphia, has been appointed director of the Prudential Health Care Plan, a Horsham-based health maintenance organization.

Barbara Troupin, a fourth-year medical student, University of Pennsylvania School of Medicine, Philadelphia, has been named as a 1994 Pisacano Scholar by the Nicholas J. Pisacano, MD, Memorial Foundation.

University of Pittsburgh Medical Center has appointed **Marc D. Feldman, MD,** associate professor of medicine, Division of Cardiology, and director, Cardiac Catheterization Laboratory.

The Philadelphia College of Osteopathic Medicine has appointed **Izola B. David, DO,** director of pediatrics.

St. Joseph's Hospital, Philadelphia, has named **Rafael Jose Revol, MD,** director of the Ambulatory Neurology Department.

University of Pittsburgh Medical Center has named **Steven Reis, MD,** director, Women's Heart Center.

Penn State's Milton S. Hershey Medical Center, Hershey, has appointed **Brian Holmes, MD,** assistant professor of surgery.

Arthur David, MD, was elected to a two-year term as a director of the Pennsylvania Academy of Family Physicians.

Atshushi Ogata, MD, was the recipient of the 1994 Brian D. Novis Research Grant, which will support his research project on the analysis of IL-6 signal transduction in myeloma.

Salvatore Mangione, MD, associate professor of medicine, Medical College of Pennsylvania, and director of the Asthma Center, has received a five-year grant from the National Heart, Lung and Blood Institute of the National Institutes of Health. In collaboration with the Asthma Task Force of Health Partners—a Philadelphia-based voluntary, nonprofit managed care organization for Medicaid recipients—Dr. Mangione will teach more advanced principles of asthma management to medical students, residents, and practicing physicians. The core of his program will be a continuing medical education program for Health Partners' medical providers.

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Pennsylvania Medical Society
Leadership Conference
May 2-3, 1995
Harrisburg Hilton and Towers

KEYNOTE ADDRESS—Jeff Levine, CNN correspondent since 1980, assigned to medical legislation and regulation activities on Capitol Hill, Washington.

PLENARY SPEAKERS *(topic titles tentative)*:

"A Look Ahead in Pennsylvania"—William L. Kissick, MD, DrPH, professor of health care systems, The Wharton School, University of Pennsylvania.

"California's Experience with Managed Care"—Eugene S. Ogrod, MD, chairman of the Board of Trustees, California Medical Association.

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- leadership and team development
- technology in the doctor's office
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For more information, complete the blanks below and fax this sheet to the Society at (717) 558-7840.

Name_____ Office Phone_____

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☐ Check if you would like to receive registration materials in February

What topics would you like to see your Medical Society leadership address in the Q&A session?

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Developing A Business Plan for Your Practice

The Health Care Group

As the American medical environment undergoes rapid change—at times akin to upheaval—most practices will be faced with a simple choice: adapt or suffer possibly terminal business losses. A surplus of about 165,000 physicians is expected by the turn of the millennium†; virtually all will be specialists. To prosper, or in some cases just to survive in this unforgiving environment, you must treat your medical specialty practice as a business, and plan for the future.

A business plan cannot insure continued growth and success, but developing and implementing one establishes the course a practice will follow to adapt to a new health care environment. Conversely, the lack of a plan will leave the physician without a road map, careening into the future in a vehicle that will become increasingly difficult to control as the terrain continually shifts and the roadway buckles.

In the typical five-step medical practice business plan, the first three steps establish a well-designed blueprint for action, the fourth sets it in motion, and the fifth keeps it dynamic, so it can change not only as better information becomes available, but also in response to unforeseen changes in the health care environment:

1) Analyze Your Practice Environment: Find out where your practice is, internally and externally. Determine, for example, your patient, referral, and payer demographics; the profitability of your services; and your hours of operation. Identify and study your competitors, the area hospitals, and the managed-care plans in your region. Find out how the practice patterns and standards have changed.

2) Define Your Practice Goals: Decide where you want your practice to be. Ask yourself and your partners, if you have them, relevant questions about important issues such as whether you want the practice to be more specialized or less, how much more income you want, which services you should offer, how large or small your practice should be, and whether you plan to retire soon.

3) Develop Your Plan: Figure out the best way to get from where you are to where you want to be. Make sure your plan is a written document, so nothing slips through the cracks or becomes uncertain over time. Start with a vision statement. Define what you want your practice to become, and how to make it so.

4) Execute Your Plan: Now, do it. It is a bad idea to file the plan in a drawer and just wait for it to happen. Wishing will not get the job done. Most plans fail because they are executed poorly or not at all.

> ***"The overwhelming majority of physicians must pay attention to the health care environment."***

5) Monitor Your Plan: You must evaluate the plan to make sure it is working well. If you are not fulfilling your goals, find out why not. Measure the plan's performance relative to steps 1-4. If the plan is not working, make the necessary adjustments.

Analyze your practice environment

If you are internationally recognized as one of the great medical doctors of all times, you have no worries; despite the environment, despite managed care, despite capitation, you will prosper. But there are very few Michael DeBakeys in the world. The overwhelming majority of physicians must pay attention to the health care environment.

With fewer patients being referred to specialists, and compensation for services either dropping or holding steady, if there is a surplus of specialists, either all specialists' income will decrease as every specialist sees fewer patients or, much more likely, some specialists will get enough patients to survive or prosper, and some will not.

Simply, there will be winners and losers. The exception to the rule is the doctor who is near retirement age, who simply coasts out to the end of his or her career. A business plan designed to help you deal with a rapidly changing, increasingly hostile health care environment will help you become a winner.

The first step is to find out what is going on. Generally, you must understand the demographics of your patients, your payers, and your referring physicians; know how they perceive you; and know what they expect of you. Know which procedures in your specialty make money and which lose money.

Outside the practice, find out what competing practitioners are doing for their patients and referrers. Find out what is going on in the hospitals. Determine which managed care plans are big in your area, and consider which ones you might want to join.

Know what legislation has been recently enacted and what is proposed—*your county and state medical society publications are key to this.* Understand how it will affect your practice of medicine and your medical business. Know what you can do to affect decisions that are pending. Keep abreast of changes in practice patterns and standards of care.

Also, because of the state of the external medical environment, specialty practice is becoming very competitive, so it is necessary to determine the sources of your business and find out how they perceive of your practice so you can cater to them.

Concentrate on your principal referring physicians. If your practice is large, determine your top 50. Visit them personally or have your practice

† *JAMA, 272(3):222-230, 1994*

administrator do it. Find out what they like and, more importantly, what they dislike about your practice. Use a standardized questionnaire. Talk to the doctor or, if the doctor will not, the office manager.

Occasionally, a referring physician may be reluctant to complain face-to-face about something he or she perceives is wrong with your business. Make it part of your job to convince these people that you really do want to know what they think. Encourage their candor.

Suppose, for example, your referrers tell you they find it difficult to reach you by phone, are kept on hold for what seems to be an eternity, and your voice-mail system is a nightmare. Your referrers will feel that they have helped you by mentioning these problems. Further, by actually looking into it, you might be able to correct a big problem, possibly with a minimum of time, effort, and expense.

And while referring physicians send you patients and represent a principal source of your business, remember that the patients are going to talk to their physicians, and if they dislike you, they will not want to visit you again. Eventually, if enough patients convince a particular referrer that they do not want to go to your office, that referrer will find somebody else to do the job. They want to keep their patients happy, and so should you.

Figure out what your patients like about your service and what they want you to do to improve it. Simply handing out checklists to patients lets them know that you really want their business and are willing to work a bit harder—take an extra step—than the competition to get it.

Use satisfaction surveys to poll your patients when they visit. Design a simple questionnaire or checklist they can fill out in a few minutes or even seconds. Ask for their optional comments at the bottom of the form. Set up a box in the office so they can drop off the forms on their way out.

Define your practice goals

You have talked to your customers, the managed-care people, the hospitals, your referring physicians, and determined what they are looking for in a specialty practice. You have researched the legal and legislative issues, and know how they may affect your business. You know your competition. Now set your goals.

The key to successful goal planning is to quantify what you want. Fulfilling a goal such as "to deliver quality care" or "to increase my income" is difficult because you cannot measure the progress you have made toward achieving it; you cannot tell if your plan is working or not.

On the other hand, suppose your goal is to improve your quality of care so that your gross annual income increases from $1 million to $1.5 million, so your personal income increases from $200,000 to $300,000, within five years. From that, it is possible to tell what your practice must look like if you are to achieve that goal, within your practice environment.

For example, perhaps you feel you are working too hard. If your goal is simply to decrease your workload, you can do that in a number of ways, but some of them may put you out of business. If you also have a goal of increasing practice revenues by drawing more patients, you can achieve both goals by decreasing your hours, expanding your service, and bringing aboard a junior associate.

> ***"A well-designed plan will include specific objectives and time frames for their accomplishment."***

Suppose you want more income. How will you get it? If reimbursement increases are impossible or decreases are pending, you must increase the number of patients you see and/or concentrate on performing only those procedures that are reimbursed at a higher rate.

Simply, your goal may be to become the number one specialty practice of its kind in your town. To do that, you may have to offer more office hours, perform more procedures and/or new procedures, market your practice more aggressively, participate more actively in managed care plans, hire another doctor (or two, or more), increase your office staff, open a satellite office, and computerize the practice. Remember to figure out how you are going to finance all that.

You may want to take a shortcut to that goal by joining an existing group. Now, instead of setting timetables and arranging financing, what you have to do is find the practice that needs to do only one thing in order to become number one in your town: Hire you.

Develop your plan

Solidify your ideas and turn them into a formal, written plan. If you fail to commit your plan to writing, it will be nebulous from the start, or it will become hazy with age. To write a useful document, you must generate specifics and think everything through to its logical conclusion.

The plan should include the resources you will need to achieve your goals. You may have to save money, borrow it, or increase your bank line. Know what it will take to accomplish your goals; do the research. Generally, it takes effort to implement a plan, and effort means cost.

A well-designed plan will include specific objectives and time frames for their accomplishment. Vague notions, such as, "Do something, as soon as possible, about controlling the accounts receivable problem," are probably doomed to fail. Do what? The plan doesn't say. When will it start? The plan doesn't address that. If it does happen, is it working up to expectations? Nobody wrote down what to expect.

Specific goals can be measured, such as, "Within six weeks, install a computerized billing and collection system to reduce the accounts receivable to less than X percent of the total accounts billed monthly, by the end of the fiscal year." Now you know what you need to do: Talk with vendors and arrange financing.

If the plan calls for hiring staff, contact A, B, and C personnel experts or put ads in publications D, E, and F; do it before the end of the current business quarter. If you want to join a plan, call X number of plans in which you do not now participate by Y date to investigate. If you want to enlarge the practice, generate a list of candidates—or at least qualifications—and start that process. →

Implement your plan

Typically, when a medical practice's business plan fails, it does so because it was implemented poorly or not at all. Consider the following three case studies.

A subspecialty cardiology practice decided to expand geographically by opening two new offices in nearby towns, so that patients could get their services locally. The idea made sense, but the group performed no demographics study, contacted no referrers, and sent out no announcements. The cardiologists rented the new offices, arranged for telephone service, then contacted a handful of referrers. The result? Two phone calls and one patient seen during the first six months. These physicians are now considering closing one of the new offices.

An MRI center loses an average of one scan a day because of the telephone-answering system. Typically, the referrer calls, cannot get through, and hangs up to phone a different center. On average, an MRI scan costs $800. Losing one a day for 20 working days a month and 12 months a year, this center is losing $192,000 a year. In comparison, adding another phone line, or even hiring a new employee—especially a part-timer—costs very little.

An ophthalmology practice created a plan which was designed, in part, to boost revenue by contacting and setting up appointments for patients who had not been to the office for service within the previous two years. The plan was working, but implementation was not.

The doctor was gung ho for the project when he assigned it to his staff, and they responded in kind. But the existing staff was already fairly severely overworked, and the doctor said to go through the files "whenever you can." So, the staffers made the time for a few weeks, but as the doctor's interest waned, the staff found less and less time to do the extra work, and finally, it just stopped. The staff had gone through the charts from "A" to "D."

If the plan is worth doing, it is worth doing well. The doctor could have hired a part-timer, perhaps a student working after school, to do it, and paid a few dollars for the service.

Monitor your plan

You have the plan, it is a statement of your vision, it incorporates your research and your goals. You finally have it up and running. One problem: There are no results. Or worse, the results are all wrong. But the plan is the plan, and you worked hard to put it together, so you'll just keep right on going until you get it right. Right?

Wrong. Evaluate the plan's performance objectively and make whatever corrections are necessary. Find out why it went wrong. Has the competition changed radically? Has your practice changed? Have you changed? Did you miscalculate something? Move a decimal point the wrong way? You wrote down the plan and included specifics in order to monitor it. Now, use these specifics for assessment.

Perhaps you haven't had any results yet because it took four months to install the system, because you had to wait for the financing, or the two biggest vendors could not fit you in. Perhaps the results are wrong because of a problem in the software, or because you really don't understand how to use the system. Maybe you wanted to reduce accounts receivable to zero, but have since discovered that this is impossible.

Perhaps the entire plan has to be revised because you received a merger proposal you couldn't refuse. Maybe your plan is entirely obsolete because you sold your practice to MegaCare Intercontinental. Then again, maybe that was your plan from the beginning.

At the end of this process, at the very least, you should understand your practice, your practice environment, your goals, and how to achieve them better than you did before you started. And you should have a vehicle that will get you from where you are to where you want to be, and the means to steer that vehicle effectively.

The contributing author, Zvi Weinman, MBA, is a consultant with The Health Care Group, Plymouth Meeting.

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Key to Plan Is Good Market Assessment

Physicians who are trying to begin a physician organization (PO) can be paralyzed by the number and scale of decisions that must be made. Paralysis in business decision making can be destructive to groups of physicians who, if organized, could have significant strength. A market assessment can give physicians the information they need to overcome decision-making paralysis, by determining the type of business organization required to successfully integrate physicians in a particular area and forming the foundation for any physician organization's business plan.

The following are a few of the major factors that must be addressed when conducting such a market assessment:

- clarify key stakeholders, and identify decision makers;
- establish the objectives of the PO and develop a vision statement;
- determine educational needs of the physicians who will be asked to join the organization;
- determine the level of autonomy that is required by the physicians;
- identify key strategic issues and critical success factors: national/state trends and local initiatives, local health market assessment of capacity and use of resources, competitor analysis, physicians' mix and profile, key employers, and relationship between the physicians;
- identify quality assurance and utilization review methods;
- anticipate competitors' responses, and minimize the impact;
- identify the financial impact of a PO, including investment and resources required, anticipated benefits, and financial impact on physicians' individual practices; and
- address management and governance issues.

Another important aspect of developing a PO is compliance with Federal Trade Commission guidelines and, in particular, antitrust laws, Medicare and Medicaid regulations, and other legal and regulatory requirements.

Any market assessment must look at the degree of physician integration necessary to succeed and compare it to the degree of integration acceptable to the physicians involved. Long after it is formed, the organization will continue to need this feedback and information base for sound decision making.

The Physician's Image: How's Your Spin, Doctor?

David Woods

The medical society of a southern state is about to launch an inquiry into what the populace thinks of physicians. It could save its members' money. As retired Philadelphia orthopod John J. Gartland, MD, a former president of the American Academy of Orthopaedic Surgeons, puts it in his admirable book, *Medical Writing and Communicating,* "Most patients seem to like their personal physicians, but have a poor and often deteriorating image of physicians as professionals."

What to do? Feel put upon and misunderstood? Appoint "spin doctors" to burnish the profession's public relations? Not a bit of it.

The pharmaceutical industry, which employs tens of thousands, spends millions of dollars on research, contributes immeasurably to our health and well-being, and accounts for a mere eight percent of the gigantic U.S. health care tab, is still a sitting target for many critics. It has a good story to tell, and it has the resources to tell it. Yet, the *way* it tells it—its public relations—leaves much to be desired.

So far as the medical profession is concerned, does the public know that many of its members don't start earning any money until they're in their late twenties or early thirties? Or that they may be in debt, even then, to the tune of $50,000 or $100,000? Or that their malpractice premiums may eat up to $100,000 a year for some "high-risk" specialties? Or that medical decisions based on eight or more years of training may be second-guessed by a high school graduate in an insurance company? Or even that physicians themselves account for only 10 percent of the overall costs of health care in this country?

Of course not. The man in the street (who, by the way, really ought to be in a library researching his facts) cares only that he's paying more and more for coverage, that he's dealing with overburdened doctors and hospitals, and that he's still trying to sort out the gibberish in which most health care information is couched.

The fact is, physicians make a pretty easy target for the *iatrectomists*—those who delight in cutting them up, or down to size. The doctor bashers.

There are those who say medicine has become too depersonalized. Yet, the public wants the best and latest drugs and technology, and physicians' use of these weapons against disease is in part a reaction to the very criticism that predated their arrival—that medicine was too *un*scientific.

The answer to all of this may be as simple as that of the foreign intern who, upon inquiring about a patient's health and being told, "Gee, Doc, I feel lousy," began to search the patient's scalp for *Pediculus Capitis.*

What's needed, I think, is an historical perspective. Physicians have always been an easy target. Remember Ambrose Bierce's definition in his *Devil's Dictionary?* "A physician is one upon whom we set our hopes when ill and our dogs when well." Also needed is an awareness that you're not being singled out for public opprobrium. Former CBS newscaster Walter Cronkite has said of journalism: "I'm sick and mighty tired of this profession of ours being constantly dragged into the operating room and dissected, probed, swabbed and needled to see what makes it tick."

So far as narrowing your collective image gap is concerned, consider:

- running for political office: In last month's elections, three MDs ran for the Senate, 10 for the House, and an average of one per state for state office.
- engage in community service.
- present a united and proactive front.
- support your medical societies.

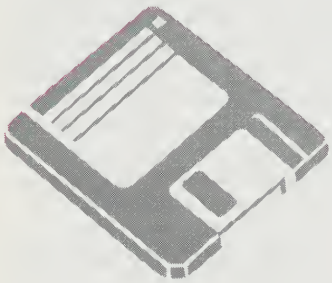
As John C. Nelson, MD, a member of the AMA's Board of Trustees, puts it: "As a profession, we have to work harder on our PR. Too often we get hit with cheap shots that stick because we haven't the time or avenue to respond. But it's critical that we take time to teach journalists and critics of medicine what it means to be a physician." That way you won't need any spin, doctor.

"A physician is one upon whom we set our hopes when ill and our dogs when well."

Mr. Woods, former editor and publisher of the **Canadian Medical Association Journal,** *is president of Healthcare Media International, Inc., Philadelphia, and a frequent commentator on health care issues.*

Rocking Along with Grateful Med®

Fred D. Baldwin



Grateful Med® isn't a physicians' rock group; it's a piece of computer software for searching MEDLINE®, a seven-million-record medical database. This second in a series of articles on new medical technologies available to physicians tells how to get Grateful Med and how to use it.

"It's easier than flipping through a book," a staff physician at a Geisinger clinic says about searching MEDLINE, a bibliographic database maintained by the National Library of Medicine and containing over seven million records.

One of the easiest ways to connect to MEDLINE from a personal computer in your office or home is by using a piece of communications software called Grateful Med. It's a bargain. Developed by the National Institutes of Health for use by physicians, it costs only $29.95. That includes a manual and free upgrades.

If you already have either an IBM-compatible or Macintosh computer and printer, the only other hardware you'll need for online searches is a modem, a device that enables your computer to make connections with other computers using regular voice telephone lines.

When you run Grateful Med, by typing the command "SEARCH," the first screen you see contains brief operating instructions that you can print out if you wish. The next screen, marked ACTION, invites you to select what you want to do. The first time you run the program, Grateful Med automatically puts you into a SETUP program so that you can enter local phone numbers. After that, you'll usually select "MEDLINE: Search Biomedical Journals."

You arrive at the main search screen. You're told, simply: "Input Your Search." If you're looking for a particular author or title, you just type entries into the labeled blanks. Remember, if the only author you know is someone named "Smith," you're going to get a lot of "hits" (records matching your search criteria), so add limits to your search. For example, you'll later be invited to limit the search to a specific journal or journals, if you want to do that.

More commonly, you'll be leaving author and title entries blank and doing a subject search. That's when Grateful Med begins to demonstrate that computer-assisted searching isn't just 10 times *faster* than using print references like *Index Medicus*; it's also *smarter*, in that you're more likely to find what you're looking for.

Move your screen cursor to the subject line, but don't type in your own first guess at a subject heading. Instead, get into the habit of tapping the "F10" key on your keyboard. This calls up MEDLINE's list of keywords, known as MeSH (Medical Subject Headings).

You'll next be invited to enter the first few letters of where you want to look in the list. For example, if you're interested in breast cancer, you might type BREAS. You'll immediately be shown a range of choices from BREAST, CYST to BREAST, XERORADIOGRAPHY. Grateful Med will also suggest that you check entries under MAMMA- and MAST-.

Some entries will be followed by a "+" sign, indicating that they contain more specific headings that you can inspect and select on screen. If you can't find an appropriate MeSH term, then you can go back to the "Input Your Search" menu and type one in, one word on each subject line.

After making your selections, make sure to check how your subject entries appear on your screen. Two subjects on a single line are the equivalent of a logical OR, meaning that you'll get everything on either subject. For example, if you search MASTECTOMY *or* POSTOPERATIVE COMPLICATIONS, you'll get not only hundreds of mastectomy entries but everything on postoperative complications after any surgery, including prostate surgery. You'll usually want concepts typed in on two different lines, as in MASTECTOMY *and* POSTOPERATIVE COMPLICATIONS. This will exclude citations that don't fit both headings combined.

***Mr. Baldwin, a contributing author from Carlisle, is currently co-authoring a book for Little, Brown & Co., with the working title,* Finding the Best Treatment: A Consumer's Guide to Medical Information.**

By the way, you're not online yet. If you've made a mistake, you can correct it by re-entering any line. What you've done so far has taken you only a couple of minutes and cost you no money.

You can make other choices if you wish, or you can use Grateful Med's defaults, such as limiting a search to articles published within the past three years. (In computerese, a *default* choice is what you get when you don't ask for anything special.) You can easily change Grateful Med's built-in assumptions—e.g., you can ask to see only English-language articles, going back in some cases as far as the late 1960s, or perhaps *only* review articles.

Connecting to MEDLINE

You're now ready to tell Grateful Med to make actual connections to MEDLINE. When you do, you'll be asked whether you want to see abstracts. On your first pass, you should probably say "no." There may be hundreds of articles on the post-operative complications of mastectomies, and it'll take more time online to recover abstracts than just citations. But don't worry if you get more hits than you expected; if you get more than 50, Grateful Med will show a few, then stop and ask if you want to continue or quit.

When you finally tell Grateful Med to search, you'll hear some buzzing and clicking as your modem dials MEDLINE, followed (if all goes well) by those coded greetings that computers exchange whenever they meet. Soon, what you want will scroll by on screen—fast. In fact, it'll go by faster than you can read it, and, abruptly, Grateful Med will hang up. You may think you've missed the whole show, but don't be alarmed: Your search results are saved automatically on your computer's hard disk.

If your search was an average one, it cost you about $1.25—billable to a credit card, if you wish. The exact amount depends on your actual time online, which in turn depends on the number of hits and whether you asked for abstracts as well as citations.

Grateful Med will give you a chance to review your search results and to save them to a permanent file; otherwise, they'll be erased the next time you go online. After you've narrowed your search to your satisfaction, you can make a second pass to ask for abstracts, or, if you know what you want, you can ask for abstracts by a unique item number.

If you want a copy of the full text of the article and your nearest medical library doesn't carry the journal, Grateful Med lets you order via a feature called Loansome Doc®. Charges per article may approach $8 by mail, $16 by FAX. Taking advantage of Loansome Doc will also require an extra one-time step to establish an account with a medical library.

If you prefer to search MEDLINE without using Grateful Med's menu prompts, you can select the DIRECT option on the initial ACTION screen. When you know the keywords you want, this approach can be faster, and it permits you to sharpen your search focus with a logical AND NOT function, as in MASTECTOMY *and* POST-OPERATIVE COMPLICATIONS, *and not* RECONSTRUCTIVE SURGERY. If you choose this direct route, you probably should order *The Basics of Searching MEDLINE* for $25.50; otherwise, the book isn't necessary. Remember that it's especially important to plan any direct search strategy offline, while the meter isn't running.

The National Library of Medicine is generous in its support of Grateful Med. You get free periodic upgrades and an automatic subscription to a newsletter called "Gratefully Yours," which describes changes to the library's databases and offers tips on effective searching. Grateful Med also enables you to search other MEDLARS® databases, including PDQ (Physician's Data Query), which lists cancer treatments and investigational protocols.

Overall, how difficult is the whole process? The first time you do it, it feels about like programming a VCR with a less-than-brilliant user's manual. That is, it's just puzzling enough to be a source of minor frustration. After that, it's almost as easy as using your TV set. It shouldn't faze any physician who wants near-instant references to over 3,600 medical journals and feels at least as smart as millions of people who regularly program VCRs to capture "I Love Lucy" re-runs. ⬡

Editor's note: Subsequent articles in this series will deal with other computer-related medical topics, including the Internet.

You can order Grateful Med from the National Technical Information Service at (800) 423-9255 (for credit card orders) or by FAX at (703) 321-8547. The cost is $29.95; for purchase orders, add a $7.50 billing fee. The IBM-DOS version is order #PB92-105444 (specify 3.5-inch or 5.25-inch disks); the Macintosh version is #PB93-502433. A Windows version is promised in 1995.

For more information about Grateful Med, call the National Library of Medicine's MEDLARS service desk at (800) 638-8480. They'll send application forms and will assign you a user code/password by return mail, which otherwise you'd have to get after receiving the software. You can also order a video tutorial on the personal computer version of Grateful Med for $12.95, or consult your nearest medical library for other MEDLINE reference materials.

INFANT MORTALITY RATE HITS ALL-TIME LOW

Pennsylvania, whose infant mortality rate hit an all-time low last year, is well on its way to meeting a national goal to lower the infant death rate by the year 2000. The state's overall resident infant death rate for 1993 was 8.5 per 1,000 resident live births—a 5.6 percent decrease from the 1992 rate of 9.0 and one of the largest decreases in recent years.

A breakdown by race shows an infant death rate of 19.5 for black residents, which is almost three times higher than the 6.6 rate for white residents. The good news is that the rate for black residents declined from 20.4 in 1992. The lowest recorded rate was 19.2 in 1991.

Residents of Hispanic origin recorded a rate of 10.5 per 1,000 live births, compared to 10.0 in 1992. The infant death rate for Hispanics had decreased every year between 1989 and 1992, from 12.6 to 10.0.

Still, according to the Pennsylvania Department of Health's State Center for Health Statistics and Research, the commonwealth is in line to meet the national health status objective set for the year 2000—to lower the infant death rate to 7.0 per 1,000 live births for all races and 11.1 for blacks.

Center statistics show that infant mortality for all races has been decreasing since 1915, when statewide reporting began. However, the decrease slowed during the 1980s and into the 1990s. For more information, contact the center at (717) 783-2548.

The information in this article is excerpted from "Statistical News" of the Pennsylvania Department of Health's State Center for Health Statistics and Research, vol. 17, no. 5, September 1994.

ADDRESSING EMERGING INFECTIOUS DISEASE TRENDS

Once expected to be eliminated as a public health problem, infectious diseases remain the leading cause of death and disability-adjusted life years (DALYs) worldwide[1] and are among the leading causes of death in the U.S.[2] Dramatic changes in society, technology, and the environment, together with the diminished effectiveness of certain approaches to disease control, usher in an era wherein the spectrum of infectious diseases is expanding, and many infectious diseases once thought to be controlled are increasing.

The term "emerging infectious diseases" refers to diseases of infectious origin whose incidence in humans has either increased within the past two decades or threatens to increase in the near future.[3] Examples in the U.S. are: drug-resistant pneumococcal disease, *Escherichia coli* O157:H7 disease, Hantavirus pulmonary syndrome, and Influenza A/Beijing/32/92.

To effectively address emerging infectious diseases, the U.S. Centers for Disease Control and Prevention (CDC) has developed a strategic plan emphasizing surveillance, research, and prevention activities necessary to maintain a strong defense against infectious diseases that affect, or threaten to affect, the public's health.

The goals of this plan address priorities for surveillance, applied research, prevention and control, and public health infrastructure, respectively:

Goal I: Detect, promptly investigate, and monitor emerging pathogens, the diseases they cause, and the factors influencing their emergence.

Goal II: Integrate laboratory science and epidemiology to optimize public health practice.

Goal III: Enhance communication of public health information about emerging diseases, and ensure prompt implementation of prevention strategies.

Goal IV: Strengthen local, state, and federal public health infrastructures to support surveillance, and implement prevention and control programs.

The strategy of this plan is based on repeated experience demonstrating that it is less costly to anticipate and prevent infectious disease threats than to react with expensive treatment or containment measures to public health crises. Public health policy and practice that combine investments in surveillance, laboratory research and training, and epidemiologic investigations with prevention and control efforts will reduce the impact of emerging infectious disease threats, in terms of both human suffering and economic losses.

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Excerpted from: Centers for Disease Control and Prevention, "Addressing emerging infectious disease threats: a prevention strategy for the United States" (Executive Summary). MMWR *43(RR-5):1-16, 1994.*

NEW MAMMOGRAPHY GUIDELINES ISSUED

New clinical practice guidelines released in October by the Agency for Health Care Policy and Research (AHCPR) recommend ways to improve the quality of mammography and its potential for reducing deaths from breast cancer. The guidelines outline the roles and responsibilities of each health worker involved in the mammography process and of the woman undergoing mammography.

Among the recommendations:

- Women should schedule screening mammograms when their breasts are least tender and avoid using powders, lotions, or deodorants the day of their test, since they can affect the quality of mammograms.
- Mammography should be performed only with high quality, modern, dedicated x-ray equipment and with film processors set up specifically for the mammography film being used.
- Mammography facilities should give women test results within 10 days.
- Personnel who supply mammography services, including radiologic technologists, interpreting physicians, and medical physicists, should be qualified through appropriate training, expertise, certification, and licensing.
- Mammography facilities should have effective, ongoing quality control programs which include annual evaluation by a qualified medical physicist and more frequent quality control tests at specified intervals by a qualified radiologic technologist.

The new guidelines are the thirteenth published since 1992 by AHCPR, one of eight agencies that make up the Public Health Service of

the U.S. Department of Health and Human Services. Others published this year address: otitis media with effusion in children, treatment of pressure ulcers in adults, acute low back problems in adults, and post stroke rehabilitation.

Still under development by AHCPR are guidelines on: cardiac rehabilitation, screening for Alzheimer's disease, smoking cessation, anxiety and pain disorders, and colorectal cancer screening.

Single copies of guidelines are available free of charge from the AHCPR Publications Clearinghouse at (800) 358-9295, or from AHCPR Instant Fax at (301) 594-2800.

Other endeavors

AHCPR has also announced that it will fund a number of other endeavors:

- Grants totaling $9.7 million will support demonstrations of innovative ways to deliver health care services in rural areas of Maine, West Virginia, Oklahoma, Nebraska, Iowa, and Arizona.
- A $300,000 contract was awarded to the Research Triangle Institute, Research Triangle, North Carolina, to develop a model survey questionnaire and data collection procedures to survey consumers about their attitudes regarding access to health care, use of specific health services, health outcomes, perceived quality of care, and satisfaction with the care they receive.
- Through a $15 million, five-year cooperative agreement, the agency and the RAND Corporation will study HIV/AIDS health care, treatment costs, and sources of financing for patients. It is the largest, most comprehensive study of its kind on the subject.

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CDAC Prepares for Implementation

Donald E. Harrop, MD

After announcing the acquisition of the Clinical Data Abstraction Center (CDAC) contract in last month's issue, I thought I should provide a little more detail about what CDACs are and how we expect they will work.

Clinical Data Abstraction Centers (CDACs) were created by HCFA to centralize all medical record abstraction activities involving national cooperative projects in two locations. According to HCFA, the centers would improve consistency, and be more efficient and more economical.

Consistency is the most important consideration when we look at the reason for abstraction of records, which is to accumulate data files of cases for analysis. Inconsistent or erroneous information would make the data worthless and could lead to incorrect conclusions when the data are analyzed.

The abstraction software to be used by the CDACs has evolved from the Uniform Clinical Data Set System (UCDSS) to the Medicare Quality Indicator System (MQIS). The reason for the switch was that the UCDSS was designed only to identify *individual* cases which required physician review. However, the MQIS is a system of quality indicators used to profile *patterns of care*.

This is what the PRO Health Care Quality Improvement Program (HCQIP) is all about: analyzing patterns in processes and outcomes of care rather than individual case review. And MQIS indicators are expected to be more reliable and valid measures of quality, because they will be tested in the field and should help to produce appropriate corrective actions and measurable changes in the quality of care.

CDACs will receive a monthly sample listing of cases from HCFA for the national projects and will request from the hospitals the medical records on that list. The hospitals will send the records directly to the CDAC; the records will not pass through the PROs.

These medical records will be abstracted, and all abstracted data will be forwarded to the HCFA Central Office. Data will then be forwarded by HCFA to the appropriate PROs, and the PROs will work with the hospitals to interpret and apply the findings of their analyses in the form of improvement projects, when necessary. Providers should keep in mind that PROs will continue to request medical records directly from hospitals for project data collection for local and/or statewide projects.

While this is the essence of the CDAC operation, there are other requirements in the CDAC Scope of Work. CDACs must implement an internal quality assurance program to be certain that only accurate, reliable, and consistent data abstraction is performed, and they will be subject to confidentiality of information requirements which are as strict as those required of the PROs.

In January 1995, implementation of CDAC operations by Dyn/KePRO will begin. The center's first objective will be to start collecting data to support the Cooperative Cardiovascular Project (CCP), a national effort to improve care for patients hospitalized for acute myocardial infarction (AMI). Thirteen MQIS quality indicators have been developed for the CCP/AMI module.

Instead of taking a sample of cases, which is how future MQIS modules are expected to be handled, 100 percent of AMI discharges which occurred during an eight-month period (January 1 through August 31, 1994) will be abstracted for the CCP/AMI. This is far more intensive than the sampling levels envisioned for other improvement projects. Later in 1995, CDACs will begin to abstract data to support other modules of the MQIS.

These new concepts—CDACs and the MQIS—represent two of the most important changes impacting the PRO program since its inception 10 years ago. When combined with the HCQIP, which is also comparatively new, we see the development of a completely different PRO program, one which has the potential to facilitate meaningful improvements in health care delivery.

"These new concepts—CDACs and the MQIS—represent two of the most important changes impacting the PRO program since its inception 10 years ago."

Dr. Harrop is president of the Keystone Peer Review Organization.

Keeping Up with Mergers Proves Challenging

Keeping up with health care mergers has proven challenging in 1994. Anyone following state and national headlines is sure to understand that each merger brings new light to the changing health care environment in Pennsylvania, as well as in the U.S.

To help Pennsylvania physicians deal with these changes, this publication is continuing its coverage by compiling the following list of recent mergers from press reports. It is by no means a complete list of all that is happening in a changing health care marketplace.

• St. Joseph Hospital, Lancaster, has formed a physician-hospital organization (PHO) with the Independent Physicians Association of Lancaster. The PHO is being marketed to area employers.

• Nazareth Hospital, Philadelphia, has signed an agreement to join the Franciscan Health System, Aston.

• The Graduate Hospital, Philadelphia, and an independent practice association (IPA) formed by members of the hospital's staff have established the Graduate Physician Hospital Organization (PHO) to directly contract with third-party payers needing tertiary-level specialty medical care for their members. It is believed to be the first specialty-owned PHO in the Delaware Valley and a potential referral source for the many primary care-based PHOs that predominate in the market.

• The University of Pittsburgh Medical Center, which has formed alliances with three local hospitals, is taking the idea one step further by creating a broad, regional health care network. The goal is to provide "cost-efficient care that is offered as close to the patient as possible," said Jeffrey Romoff, president of the medical center.

• Allegheny Health, Education, and Research Foundation and the Crozer-Keystone Health System will work together to train medical professionals. Under the agreement, some medical students, residents, and other health professionals educated at Hahnemann University, which is owned by Allegheny, will get further training at Crozer-owned hospital and medical facilities. Some students and residents from the Medical College of Pennsylvania, also owned by Allegheny, will participate in the agreement as well.

• In Central Pennsylvania, negotiations continue between Independence Blue Cross and Graduate Health System. Both sides have admitted to some significant hurdles that have yet to be resolved before a merger could occur.

• Penn State's Milton S. Hershey Medical Center and Capital Blue Cross are setting up jointly operated primary care facilities; the first opened last month in State College. The management organization is called Pennsylvania Medical Management, Inc. Additional facilities are slated to open in the Harrisburg-Hershey area in 1995.

• Continental Medical Systems, Inc., has purchased the stock of Keystone Medical Systems, Inc., Lemoyne.

• Three physician alliances—Central Pennsylvania Physician Organization, Blue Mountain Physicians, and Greater Susquehanna Physicians Alliance—are operating in Harrisburg.

• The Chambersburg Hospital and Waynesboro Hospital have formed a nonprofit organization, Summit Health Alliance. Chambersburg Health Services and Cumberland Valley Medical Services also participate.

• Jeanes Hospital, Philadelphia, is exploring an affiliation with the University of Pennsylvania Health System. The Germantown Hospital and Medical Center recently affiliated with the Penn system.

• National Medical Enterprises, Inc., Santa Monica, California, has purchased American Medical Holdings, Inc., in an effort to cut expenses to be better able to compete in an increasingly cost-conscious health care system.

Delegation Submitting 11 Resolutions to AMA

The Pennsylvania Delegation to the AMA has submitted 11 resolutions to the national organization's House of Delegates for consideration at its interim meeting this month in Honolulu, Hawaii. The resolutions call for:

• a level playing field for out-of-network physicians;

• HCFA support of state medical society involvement in Medicaid DUR programs, using Pennsylvania's program as a model;

• repayment of errors in Medicare reimbursement;

• creation of an anti-tobacco lobbying effort, with help from key federal agencies and major anti-tobacco organizations;

• study of the feasibility of health insurance for dependents up to age 26;

• federal legislation and regulation to limit access to medical records;

• reimbursement for additional opinions under managed care programs;

• protection of raw material suppliers from product liability litigation;

• legislation that Medicare provide long-term care coverage;

• confirmation that the House of Delegates continues to be the AMA's legislative and policy-making body; and

• an AMA sesquicentennial celebration in Philadelphia in 1997.

Look for results of these resolutions in upcoming issues of PENNSYLVANIA MEDICINE and *Executive Report*.

COUNTY NEWS

LCMS SPONSORS FIRST HEALTH CARE SYMPOSIUM

The Lackawanna County Medical Society (LCMS) on November 9 sponsored the first annual Northeastern Pennsylvania Health Care Symposium and Medical Trade Exposition. Developed specifically for health care professionals in the region, the symposium featured educational sessions and an exhibition hall of more than 30 products and services.

Anne D. Mullaney, Esq., specialist in health care law, Nash & Company, led a day-long educational session, "Responding to Managed Care: A →

Challenge for Physicians." She discussed the dynamics of the changing marketplace, the emergence of integrated delivery systems (IDSs), different types of organizations (physician-hospital organizations, physician organizations, etc.), and the legal and organizational issues associated with IDSs. Mullaney also emphasized antitrust issues, the emergence and governance of performance standards to measure utilization, and quality changes in reimbursement methods.

Randolph D. Smoak Jr., MD, a surgeon from Orangeburg, South Carolina, and a member of the AMA Board of Trustees, presented the evening keynote address, discussing "The Impact of Reform on the Health Care System." Also, State Society President John H. Hobart, MD, talked briefly on the importance of membership in organized medicine.

BEAVER COUNTY HOLDS SECOND MINI-INTERNSHIP

The Beaver County Medical Society in September sponsored its second mini-internship program, providing an opportunity for community leaders to experience, first hand, the delivery of health care from a physician's perspective.

Seventeen community leaders participated in the program, representing county business, social service, government, and health care organizations. Among the interns were State Representative Susan Laughlin and Beaver County Sheriff Frank Policaro Jr.

Faculty physicians included: David Applegate, DO; John Baska, MD; Lawrence Bell, MD; Carol Colvin, MD; Sarah Dusenberry, MD; Eric Ehrenberg, DO; Ida Gagliardi, MD; Brude Guerdan, MD; Sheila Marshall, DO; Thomas Michael, MD; Morry Moskovitz, MD; Paul Peindl, MD; Emilia Phillips, MD; David Rafalko, MD; D. H. (Skip) Ruth, MD; Patrick Sturm, MD; John Wright Jr., MD; and Gregg Zernich, DO. Dr. Sturm chaired the program.

ALLIANCE NEWS

PMSA INSTALLS 71st PRESIDENT

Freddie Persic was installed as the 71st president of the Pennsylvania Medical Society Alliance during its annual meeting, held in conjunction with the Society's October House meeting in Hershey.

Freddie Persic

She is the wife of Louis A. Persic, MD, and a member of the Centre County Medical Society Alliance, where she has served as president, treasurer, and on the Nominating Committee. She has been active on the state level in a number of positions and has been a delegate to the AMA Alliance for five years.

At its annual meeting, PMSA adopted several amendments to its bylaws and set its priorities for 1994-95, including legislation focusing on health system reform, membership, and health projects. Sheron Andrews, Dauphin County, was elected president elect.

PENN DEDICATES RHOADS PAVILION

Dr. Rhoads

The University of Pennsylvania Medical Center and Health System in October dedicated the Jonathan Evans Rhoads Pavilion, a nine-story, $69 million, state-of-the-art patient care facility.

The pavilion, located at 36th Street and Hamilton Walk, is named after internationally known physician Jonathan E. Rhoads, MD. A professor of surgery, university provost emeritus, former John Rhea Barton professor, and chairman of surgery, Dr. Rhoads is known throughout the world for his many medical accomplishments. He received the State Society's Distinguished Service Award in 1975 "in recognition of his service in the science and art of medicine, and for his life and activities which reflect great credit on the profession."

Over the past half century, he has held more than 20 hospital and university positions. He is the father of State Society President Elect Jonathan E. Rhoads Jr., MD.

The Rhoads Pavilion contains eight patient-care floors, five specifically designed and equipped for the care and comfort of inpatients from medical, surgical, and oncology services, and three designed for the evaluation, diagnosis, and treatment of outpatients from the Departments of Transplantation, Cardiology, Dermatology, and Urology.

The building also includes approximately 220,000 square feet of private and semi-private patient rooms, doctors' offices, laboratories, conference rooms, lounges, a three-story atrium, and bridge access to other buildings. The basement houses Penn's new 17-ton, four Telsa magnetic resonance imaging unit—one of only four such powerful MRI units in the world.

FARRAR BOOK OVERVIEWS CENTURY OF MEDICINE

The Society's Educational and Scientific Trust has published, *From Black Bag to White Coat: One Doctor's Story of 20th Century Medicine*, by George E. Farrar Jr., MD, FACP. The book is a panoramic view of the major advances in medicine over the past century as seen through the eyes of its author, who was always a witness to them and frequently a participant.

A retired physician who resides in Newtown, Dr. Farrar is a former president of the Pennsylvania Medical Society and the Philadelphia County Medical Society, former chairman of the Trust, and a past recipient of the Society's Distinguished Service Award.

Copies of the book are available by calling the Trust at (800) 228-7823, extension 431. The cost is $12.95 plus tax. Proceeds from the sale of the book will be used to provide gift copies to tomorrow's physicians, the medical students of Pennsylvania.

ANNALS APPOINTS NEW EDITOR

The Board of Regents of the American College of Physicians (ACP) last month announced the appointment of Frank Davidoff, MD, Philadelphia, as editor of *Annals of Internal Medicine*, the most widely cited medical-specialty journal in the world.

Dr. Davidoff, a renowned internist, endocrinologist, and medical educator, will assume the editorship

Dr. Davidoff

early next year. A graduate of Harvard University and Columbia University College of Physicians and Surgeons, he currently serves as senior vice president for education at ACP.

According to ACP, Dr. Davidoff "brings to the editorship a broad perspective with extensive experience in patient care, research, and education." He has been a frequent contributor to medical literature and has served as a reviewer for six prominent medical journals, including *New England Journal of Medicine*, *Journal of the American Medical Association*, and *Annals*.

He also served on the editorial board of the *Journal of General Internal Medicine* and writes a column on educational issues for *ACP Observer*, the official publication of the association.

Dr. Davidoff has received numerous honors, including the 1994 Laureate Award from ACP's Pennsylvania Chapter for demonstrated excellence in medical care, education, or research and dedicated service to the community.

PITTSBURGH INSTITUTE RECEIVES CANCER GRANT

A grant of $1 million has been awarded to the Pittsburgh Cancer Institute (PCI) of the University of Pittsburgh Medical Center by the Lucille P. Markey Charitable Trust for a research program in gene therapy for cancer.

"This major award provides recognition of the accomplishments already made in gene therapy by PCI faculty and will undoubtedly accelerate the pace of our progress with this very promising and innovative strategy for improving the treatment of cancer," said Ronald B. Herberman, MD, director of PCI and principal investigator.

According to Dr. Herberman, the long-term objective of the research program is to use this molecular approach to ameliorate, or possibly correct, deficiencies in metabolism or immunity, or to stimulate the body's immune defenses against cancer.

Investigators at PCI are currently exploring optimal ways of delivering genes into the body's cells where, for instance, they may provide either limited or self-renewing sources of a therapeutic substance.

The grant will help to fund the research program in three ways, by:

1) establishing specialized facilities for gene therapy research;

2) helping recruit scientists with expertise in designing gene therapies for lung cancer, breast cancer, brain tumors, and other types of cancers; and

3) supporting innovative and promising pilot projects in gene therapy.

To date, investigators in PCI's gene therapy program have developed a number of preclinical models for treating cancer. In the fall of 1993, PCI began a gene therapy trial for patients with advanced cancer.

The Lucille P. Markey Charitable Trust was established in 1983 to support and encourage basic medical research primarily at schools of medicine. To date, it has distributed more than $455 million in grants to institutions of higher learning across the country.

FEDERAL FUNDS EXPAND HIV/AIDS SERVICES

Newly awarded funds from the federal Ryan White program for underserved people with HIV/AIDS will allow staff of the Medical College of Pennsylvania (MCP) and Hahnemann University to substantially expand services for HIV/AIDS patients in Philadelphia.

The grant will underwrite "Partnership for the People," an innovative collaboration between both schools' hospitals, the Philadelphia Department of Health, and the Philadelphia Veterans' Affairs Medical Center. While each institution currently offers clinical and support services through separate programs, under the grant, they will pool resources, expertise, and outpatient services, including comprehensive primary and dental care, case management, and risk-reduction efforts.

Also, the grant will allow the collaborating institutions to hire:

- an additional physician to provide outpatient care at the MCP and Hahnemann facilities;
- two case managers to help patients access the public and private social services available to them; and
- a risk-reduction coordinator, who will assist outpatients with reduction of behaviors that place them at risk of HIV infection, and link clients with HIV counseling and testing services.

TEN PA HOSPITALS RECEIVE TRAUMA ACCREDITATION

The Pennsylvania Trauma Systems Foundation has reaccredited Lehigh →

DRAWING HELD TO INCREASE AWARENESS OF NEW CENTER: The Society's Center for Drug Education and Information sponsored a drawing at the annual business meeting in October to increase awareness of its programs to educate physicians about drug utilization. Pictured (left to right) are: Barbara A. Layne, director of professional drug education and information, and Society Immediate Past President Martin A. Murcek, MD, who drew the winning name. Jacki Allender of Belleville, a member of the Pennsylvania Medical Society Alliance, was the winner of the grand prize—a gourmet food basket.

Valley Hospital as a Regional Resource Trauma Center. This designation, valid until September 30, 1997, is the highest accreditation awarded by the foundation and was given to nine other Pennsylvania hospitals.

To receive this accreditation, a hospital must meet standards established by the American College of Surgeons, including having trauma surgeons, nurses, and support personnel, and equipment immediately available to treat the most serious life-threatening and disabling injuries. A surgery residency teaching program is also required to support the attending surgeons.

In addition to the Regional Resource Trauma Center designation, Lehigh Valley Hospital was awarded additional qualifications in pediatric trauma, a three-year certification. This designation was also given to Penn State's Milton S. Hershey Medical Center, Hershey, and Allegheny General Hospital, Pittsburgh.

Lehigh Valley Hospital was named Pennsylvania's first Level I Trauma Center in 1981. Nearly 1,400 critically injured victims of motor vehicle and industrial accidents are treated in the hospital's trauma program each year.

GEISINGER OPENS CHILDREN'S HOSPITAL

Geisinger Medical Center, Danville, has announced the opening this month of the Janet Weis Children's Hospital, the first rural acute-care children's hospital in America.

The new hospital consolidates Geisinger's inpatient pediatric treatment centers for better communication and care. Among its "child-friendly" features are:

- a colorful, playful, non-intimidating design;
- private rooms with a TV, VCR, the Disney Channel, and places to hang "kid stuff";
- a personal message board at each room entrance;
- counters at nursing stations and other areas cut low for children;
- outdoor play decks;
- three playrooms—one is for children taking immunosuppressant drugs in the hematology/oncology-nephrology area; and
- displays of children's art from school children from throughout Pennsylvania.

NEW PRESIDENT APPOINTS COUNCILS, COMMISSIONS

State Society President John H. Hobart, MD, has appointed the following physicians as members and officers of the Society's councils and commissions for the 1994-95 term:

Council on Education and Science

Chair—Richard L. Decker, MD, *Blair*
Vice Chair—Richard D. Baltz, MD, *Dauphin*
Richard T. Bell, MD, *Berks*
Joseph B. Blood Jr., MD, *Bradford*
Gene L. Cary, MD, *Dauphin*
John J. Dennehy, MD, *Montour*
William R. Dubin, MD, *Philadelphia*
Robert J. Fagioletti, MD, *Washington*
George D. Hanzel, MD, *Cambria*
Daniel B. Kimball Jr., MD, *Berks*
Lila S. Kroser, MD, *Philadelphia*
Edward G. Liszka, *Dauphin*
Stanley P. Mayers Jr., MD, *Centre*
Robert S. Mirsky, MD, *Bucks*
John H. Moyer, MD, *Dauphin*
Nancy S. Nieland-Fisher, MD, *Allegheny*
Harry P. Palkovitz, MD, *Allegheny*
Robert S. Pyatt Jr., MD, *Franklin*
Russell J. Stankiewicz, MD, *Union*
Bryce Templeton, MD, *Philadelphia*

Commission on Continuing Medical Education

Chair—Robert S. Pyatt Jr., MD, *Franklin*
Robert C. Aber, MD, *Dauphin*
Judith A. Black, MD, *Allegheny*
Paul W. Dishart, MD, *Allegheny*
John H. Esbenshade II, MD, *Lancaster*
Walter I. Hofman, MD, *Montgomery*
Julian Katz, MD, *Philadelphia*
Brian W. Little, MD, *Lehigh*
Carmela F. deRivas, MD, *Montgomery*
Bradford K. Strock, MD, *Dauphin*
Michael J. Warhol, MD, *Philadelphia*

Council on Governmental Relations

Chair—Charles D. Hummer Jr., MD (Delaware)
Vice Chair—Lawrence L. Altaker, MD (Dauphin)
A. Craig Brown, MD, *Erie*
David L. Cohen, MD, *York*
James F. Evans, MD, *Montour*
Joseph A. Giordano, MD, *Mercer*
Andrew W. Gurman, MD, *Blair*
Carolyn J. Kubik, MD, *Allegheny*
Lynn Michele Lucas-Fehm, MD, *Philadelphia*
John S. Parker, MD, *Westmoreland*
Gordon S. Perlmutter, MD, *Berks*
W. Gale Reish, MD, *Union*

Council on Medical Economics

Chair—James J. Houser, MD, *Venango*
Vice Chair—John R. Martell Jr., MD *Allegheny*
James D. Balshi, MD, *Northampton*
Carl J. Forster, DO, *Schuylkill*
Veryl F. Frye, MD, *Clinton*
Richard M. Gash, MD, *Philadelphia*
George R. Green, MD, *Montgomery*
Barbara M. Harley, MD, *Cambria*
Howard G. Hughes, MD, *Montour*
Anthony M. Perry, MD, *Lackawanna*
William R. Poller, MD, *Allegheny*
David M. Rafalko, MD, *Beaver*
Bruce G. Silver, MD, *Delaware*
Bruce L. Thomas, MD, *Huntingdon*
Anne M. Woods, MD, *York*
L. Alan Wright, MD, *Allegheny*

Council on Medical Practice

Chair—Barbara E. Barnes, MD, *Erie*
Vice Chair—Jeffrey H. Chaby, DO, *Lancaster*
Charles Cutler, MD, *Montgomery*
Donald E. Martin, MD, *Lebanon*
Thomas A. O'Boyle, MD, *Monroe*
John P. Pagana, MD, *Northumberland*
James G. Pitcavage, MD, *Allegheny*
Fred Teichman, MD, *Union*
Edward M. Zimmerman, MD, *Beaver*

Council on Membership

Chair—Wilma C. Light, MD, *Westmoreland*
Vice Chair—Arthur V. Stein, MD, *Lehigh*
Richard P. Albertson, MD, *Montgomery*
Charles J. Cattano, MD, *Allegheny*
Mark S. Friedlander, MD, *Delaware*
Eric J. Gertner, MD, *Philadelphia*
Daniel J. Glunk, MD, *Lycoming*
David R. Haas, MD, *Dauphin*
Norman Makous, MD, *Philadelphia*
James A. Morris Jr., MD, *Delaware*
Jason R. Soss, *Philadelphia*
Gloria J. Watkins, MD, *Westmoreland*

State Society Applauds Tobacco-Free Pharmacies

More than 400 pharmacies statewide that do not sell tobacco products were recognized by the State Society in November for their anti-smoking stance. During a news conference in the State Capitol the day before the American Cancer Society's "Great American Smokeout," several representatives of the 400 pharmacies received certificates for being "tobacco-free."

The State Society, in cooperation with the Pennsylvania Pharmacy Association, has sponsored the pharmacy recognition program since 1991; it awarded certificates to 77 pharmacies last year. Immediate Past President Martin A. Murcek, MD, told reporters, "I applaud these more than 400 pharmacies across Pennsylvania for standing on the belief that they are in the business of helping sick people, not helping make people sick."

For additional information about this program, contact the Society's Department of Public Affairs, (800) 228-7823.

ADAMS COUNTY
Lifeline Pharmacy, *Biglerville*
Adams & Cumberland Pharmacy, *Gardners*
Oxford Pharmacy, *New Oxford*

ALLEGHENY COUNTY
Med-Fast Pharmacy, *Baden*
The Medicine Shoppe, *Bridgeville, Ingomar, Bellevue, Pittsburgh, Brentwood, Munhall*
Blackburn's Physicians Pharmacy, *Tarentum*
Medi Pharmacy, *Allison Park*
Porter's Prescription Pharmacy, *Coraopolis*
Steel Valley RX Center, *Homestead*
Bob Aber Pharmacy, *Munhall*
Manns Drug Store, *White Oak*
Thomas Drug Co., *McKeesport*
Kay Drug Company, *Pittsburgh*
Choice Pharmacy, *Pittsburgh*
Amcare Health Services, *Pittsburgh*
Giant Eagle Pharmacy, *Pittsburgh*

ARMSTRONG COUNTY
Wyble's Pharmacy, *Apollo*
Klingensmith's Drug Store, *Elderton*

BEAVER COUNTY
The Medicine Shoppe, *Aliquippa, East Rochester*
A & G Pharmacy Services, *Aliquippa*
Thrift RX, *Aliquippa*
Ernie's Pharmacy, *Midland*

BEDFORD COUNTY
Letrent's Pharmacy, *Bedford*
Fisher's Pharmacy, *Bedford*
Ickes Drug Store, *Bedford*
Everett Pharmacy, *Everett*

BERKS COUNTY
Adams & Bright, *Hamburg*
Penn Pharmacy, *Reading*
The Medicine Shoppe, *Reading*
Union Prescription Center, *Reading*
Colonial Pharmacy, *Reading*
Brunner's Pharmacy, *West Reading*

BLAIR COUNTY
RI Group, *Altoona*
The Medicine Shoppe, *Altoona*
Kopp Drug Express, *Altoona*
Kopp Drug Store, *Bellwood, Hollidaysburg, Tyrone*
Community Pharmacy, *Tyrone*
Med-Center—Tyrone, *Tyrone*

BRADFORD COUNTY
Clinic Pharmacy, *Sayre*
Plaza Pharmacy, *Wyalusing*

BUCKS COUNTY
Whitman Pharmacy, *Holicons*
Godshall Pharmacy, *Perkasie*
Village Pharmacy, *Plumsteadville*
Script Shoppe Pharmacy, *Quakertown*
The Medicine Shoppe, *Quakertown, Souderton, Warminster, Feasterville*
Keebler Pharmacy, *Richboro*
Bowen's Pharmacy, *Holland*
Northwest Pharmacy, *Ivyland*
AARP Pharmacy Service, *Warminster*
Drug Emporium, *Levittown*
Clover Pharmacy, *Morrisville*

BUTLER COUNTY
The Medicine Shoppe, *Butler, Zelienople*
Petrolia Pharmacy, *Petrolia*
Carmark Pharmacy, *Cranberry Township*
Walmart Pharmacy, *Cranberry Township*

CAMBRIA COUNTY
Watters Brothers Drug Store, *Barnesboro*
Union Prescription Center, *Johnstown*
The Medicine Shoppe, *Johnstown*
Rinehart's Pharmacy, *Nanty-Glo*
Forest Hills Pharmacy, *St. Michael*

CAMERON COUNTY
Lundberg Pharmacy, *Emporium*

CARBON COUNTY
Jim Thorpe Pharmacy, *Jim Thorpe*
Harleman's Pharmacy, *Lehighton*
Weatherly Area Community Pharmacy, *Weatherly*

CENTRE COUNTY
Boalsburg Apothecary, *State College*
Prescription Center, *State College*
Penn's Valley Pharmacy, *Spring Mills*

CHESTER COUNTY
Thrift RX, *Wayne*
Village Apothecary, *Honey Brook*
Durant Medical, Inc., *Malvern*
Caremark, Inc., *Malvern*
Moore's Pharmacy, *Thorndale*
Southern Chester County Pharmacy, *West Grove*

CLARION COUNTY
The Medicine Shoppe, *Clarion*
Caruso Drug Store, *New Bethlehem*
Klingensmith's Drug Store, *Rimersburg*

CLEARFIELD COUNTY
S & S Pharmacy, *DuBois*
The Medicine Shoppe, *DuBois, Clearfield*
Bell's Drug Store, *Coalport*

CLINTON COUNTY
Keller & Munro, Inc., *Lock Haven*

COLUMBIA COUNTY
Hospital's Apothecary, *Bloomsburg*
Colonial Pharmacy, *Millville*
The Medicine Shoppe, *Berwick*

CRAWFORD COUNTY
Thrift Drug, *Conneaut Lake*
Option Care Pharmacy, *Meadville*
Jack's Pharmacy, *Meadville*
E. K. Thompson & Son Pharmacy, *Titusville*

CUMBERLAND COUNTY
West Shore Pharmacy, *Camp Hill*
Cumberland Apothecary, *Camp Hill*
The Medicine Shoppe, *Carlisle, Mechanicsburg, New Cumberland*
Penrose Place Pharmacy, *Carlisle*
BMC Pharmacy, *Carlisle*
Carlisle Apothecary, *Carlisle*

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Emerald Drug Stores, *Mechanicsburg*
Holly Pharmacy, *Mt. Holly Springs*
MGM Pharmacy, Inc., *Newville*
R. T. Henry Pharmacy, *Shippensburg*

DAUPHIN COUNTY
Deibler's Drug Store, *Elizabethville, Lykens*
The Hershey Pharmacy, *Hershey*
Pease Pharmacy, *Harrisburg*
Emerald Drug Stores, *Harrisburg*
ConPharma Home Health Care, *Harrisburg*
The Medicine Shoppe, *Harrisburg*
Uptown Professional Pharmacy, *Harrisburg*
Managed Care RX, *Harrisburg*
Agypt's Pharmacy, *Harrisburg*
Pharmacy Corporation of America, *Harrisburg*
Medicap Pharmacy, *Harrisburg*
Caremark, Inc., *Harrisburg*
Amcare Health Services, *Harrisburg*
Pennsylvania Care Systems, *Harrisburg*

DELAWARE COUNTY
ViCARE Pharmacy, *Broomall*
Rea's Pharmacy, *Chester*
Aston Pharmacy, Inc., *Aston*
Pharmacy Express, *Aston*
The Medicine Shoppe, *Brookhaven, Morton, Sharon Hill*
Public Drug of Darby, *Darby*
Thrift RX, *Darby*
DELCO Apothecary, Inc., *Drexel Hill*
Sherby Pharmacy, *Drexel Hill*
Murray Overhill Pharmacy, *Media*
Beckett Apothecary, *Sharon Hill*

ELK COUNTY
Bennett's Valley Pharmacy, *Weedville*

ERIE COUNTY
The Medicine Shoppe, *Fairview, Erie*
Girard Pharmacy, *Girard*
Waterford Apothecary, *Waterford*
Regional Cancer Center Pharmacy, *Erie*
Hillside Apothecary, *Erie*
Hillside LTC Apothecary, *Erie*
Hillside Apothecary Annex, *Erie*
Union Prescription Center, *Erie*
Lawrence Park Apothecary, *Erie*

FAYETTE COUNTY
The Medicine Shoppe, *Uniontown, Connellsville*
Medicap Pharmacy, *Uniontown*
Reed's Rexall Drugs, *Brownsville*
Fairchance Pharmacy, *Fairchance*
Health Center Pharmacy, *Farmington*
Smithfield Pharmacy, *Smithfield*

FOREST COUNTY
Forest County Medical Center Pharmacy, *Tionesta*

FRANKLIN COUNTY
The Medicine Shoppe, *Chambersburg, Waynesboro*
Village Square Pharmacy, *Chambersburg*
Park Avenue Pharmacy, *Chambersburg*
Savage-Minnich's Pharmacy, *Waynesboro*

GREENE COUNTY
McCracken Pharmacy, *Waynesburg*

HUNTINGDON COUNTY
Orby Pharmacy, *Orbisonia*

INDIANA COUNTY
Diamond Drugs, *Indiana*
Gatti Pharmacy, *Indiana*

JEFFERSON COUNTY
The Medicine Shoppe, *Punxsutawney, Brookville*
Means & Lauf Drug Company, *Brookville*

JUNIATA COUNTY
Keifer's Pharmacy, Inc., *McAlisterville*
Total Life Care Pharmacy, *Mifflintown*

LACKAWANNA COUNTY
The Medicine Shoppe, *Clarks Summit, Scranton*
Tuzze's Pharmacy, *Mayfield*
James & James Pharmacy, *Scranton*
The Medicine Shoppe #1261, *Scranton*
The Apothecary, *Moosic, Scranton*

LANCASTER COUNTY
Sloan's E-Town Pharmacy, Inc., *Elizabethtown*
Kreamer Pharmacy, Inc., *Elizabethtown*
Royer Pharmacy, *Akron, Ephrata*
Kurtz Pharmacy, *Christiana*
Anderson Pharmacies, *Denver*
Longenecker Pharmacy, *Gap*
McElroy Pharmacy, *Lititz*
Sloan's Manheim Pharmacy, Inc., *Manheim*
Sloan's Mt. Joy Pharmacy, *Manheim*
Sloan's Mountville Pharmacy, *Mountville*
Stauffer's Drug Store, *New Holland*
Neffsville Pharmacy, *Lancaster*
Wiley's Pharmacy, *Lancaster*
Williams Apothecary, *Lancaster*
Lancaster Surgical Supply & Apothecary, *Lancaster*
Red Rose Pharmacy, *Lancaster*
Willow Pharmacy, *Willow Street*

LAWRENCE COUNTY
The Medicine Shoppe, *New Castle, Ellwood City*
Your Prescription Center, *New Castle*
Thrift Drug, *New Wilmington*

LEBANON COUNTY
Donough Pharmacy, *Lebanon*
Saylor's Pharmacy, *Lebanon*
Loehle Pharmacy, *Lebanon*
Kurtz Pharmacy, *Myerstown, Schaefferstown*

LEHIGH COUNTY
Hartzell's Pharmacy, *Catasauqua*
Keiper's Pharmacy, *Allentown*
S. H. Pharmacy, *Allentown*

LUZERNE COUNTY
Waschko's Pharmacy, *Hazleton*
Johnson's Pharmacy, *Hazleton*
The Prescription Center, *Nanticoke*
Spotanski's Pharmacy, *Nanticoke*
The Medicine Shoppe, *Nanticoke, Wilkes-Barre*
The Prescription Center, *Wilkes-Barre*
Crossroads Pharmacy, *Wilkes-Barre*
Tyler Family Pharmacy, *Dimock*

LYCOMING COUNTY
Concured Pharmacy Services, *Williamsport*
Medicap Pharmacy, *Williamsport*
E. H. Bernstine Pharmacy, *Williamsport*
Divine Providence Hospital Pharmacy, *Williamsport*
Health Services Pharmacy, *Williamsport*
Montgomery's Pharmacy, *Hughesville, Montgomery*
Lehman's Pharmacy, *Jersey Shore*
Wallace Pharmacy, *Montoursville*
PNS Pharmacy, *Muncy*
Muncy Valley Hospital, *Muncy*
Harter's Drug Store, *Muncy*

MCKEAN COUNTY
Bradford Pharmacy, *Bradford*
The Medicine Shoppe, *Bradford*
Temple Pharmacy, *Kane*
DeMott's Pharmacy, *Port Allegany, Smethport*
Buchanan Brothers' Pharmacy, *Smethport*

MERCER COUNTY
The Medicine Shoppe, *Greenville, Grove City, Sharon, Hermitage*
Rhoades Medical Pharmacy, *Greenville*
Mercer Apothecary Shoppe, *Mercer*
Thrift Drug, *Mercer*

MIFFLIN COUNTY
Lewistown Pharmacy, *Lewistown*

MONROE COUNTY
Sandt's Pharmacy, *Brodheadsville*
Total Home Health Care, *Stroudsburg*
Tannersville Pharmacy, *Tannersville.*

MONTGOMERY COUNTY
Brensinger's Pharmacy, *Pennsburg*
Leedom & Wissler Pharmacy, *Abington*
Maplewood Pharmacy, *Abington*
Broad Axe Pharmacy, *Ambler*
Ambler Pharmacy, *Ambler*
J. B. Merrick Apothecary, *Ardmore*
K-Mart Pharmacy, *Willow Grove*
John F. Dettrey Pharmacy, *Wyndmoor*

Joel Family Pharmacy, *Hatboro*
Advantage Health Services, *Horsham*
Prescription Delivery System, *Horsham*
Option Care Pharmacy, *Horsham*
Drug Emporium, *Montgomery*
Rx Services, *Jenkintown*
West Park Drugs, *Merion Station*
Medical Associates, *Willow Grove*
Lankenau Apothecary, *Wynnewood*
Care's Pharmacy, *Norristown*
Vink's Pharmacy, *Norristown*
Suburban Apothecary, *Norristown*
The Medicine Shoppe, *Jeffersonville, Pottstown*
NMC Homecare, *King of Prussia*
US Home Care, *King of Prussia*
Trooper Pharmacy, *Fairview Village*
Professional Home Care Services, *Pottstown*

MONTOUR COUNTY
Grandview Pharmacy, *Danville*
Geisinger Knapper Clinic Pharmacy, *Danville*

NORTHAMPTON COUNTY
Bath Drugs, *Bath*
Family Prescription Center, *Bethlehem*
CRX #59, *Bethlehem*
Boerstler's Pharmacy, *Bethlehem*
Hess Pharmacy, *Bethlehem*
Smith's Pharmacy, *Easton*
Nazareth Pharmacy, Inc., *Nazareth*
Bechtel's Pharmacy, *Walnutport*

NORTHUMBERLAND COUNTY
In Care Pharmacy, *Sunbury*
Dal-Hern Pharmacy, *Herndon*
Uptown Pharmacy, *Mt. Carmel*
Norry Pharmacy, *Northumberland*
Tom Olcese Pharmacy, *Shamokin*
The Medicine Shoppe, *Shamokin*

PERRY COUNTY
Emerald Drug Stores, *Duncannon*
West Perry Pharmacy, *Loysville*
Bloomfield Pharmacy, *New Bloomfield*
Welfley Pharmacy, *Newport*

PHILADELPHIA COUNTY
Spruce Street Medical Pharmacy, *Philadelphia*
Barclay Pharmacy, *Philadelphia*
Bergman's University City Pharmacy, *Philadelphia*
Squire Drugs, *Philadelphia*
Pharmacy Plus Ltd., *Philadelphia*
Serve Rite Pharmacy, *Philadelphia*
Palmer Apothecary, *Philadelphia*
Today's Pharmacy, *Philadelphia*
Somerton Apothecary, *Philadelphia*
Battin & Lunger Pharmacists, *Philadelphia*
Medi-Save Pharmacy, *Philadelphia*
Wyoming Avenue Apothecary, *Philadelphia*
Hal's Pharmacy, *Philadelphia*
Mansion Pharmacy, *Philadelphia*
David's Pharmacy, *Philadelphia*
Haussmann's Pharmacy, *Philadelphia*
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Lehigh Apothecary, *Philadelphia*
City Avenue Apothecary, *Philadelphia*
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Fifth Street Pharmacy, *Philadelphia*
Cambria Pharmacies, *Philadelphia*
Richmond Medical Pharmacy, *Philadelphia*
Raker's Pharmacy, *Philadelphia*
Bridesburg Pharmacy, *Philadelphia*
Metro Pharmacy, *Philadelphia*
Center Pharmacy, *Philadelphia*
Temple University Hospital Pharmacy, *Philadelphia*
Park Prescriptions, *Philadelphia*
Delco Pharmacy, *Philadelphia*
Banks Apothecary, *Philadelphia*
Bill's Pharmacy, *Philadelphia*
United Pharmacy, *Philadelphia*
Friendly Pharmacy, *Philadelphia*
The Medicine Shoppe, *Philadelphia*
Rosica Pharmacy, *Philadelphia*
Nichol's Pharmacy, *Philadelphia*
Bergman's South Street Pharmacy, *Philadelphia*
Broad Street Pharmacy, *Philadelphia*
GHS Apothecary, *Philadelphia*
HealthSpring, *Philadelphia*
Society Hill Pharmacy, *Philadelphia*
Bank's RxD Pharmacy, *Philadelphia*
Shelly's Medication Services, *Philadelphia*

POTTER COUNTY
Sprout's Drug Store, *Shinglehouse*
Galeton Drug Store, *Galeton*

SCHUYLKILL COUNTY
Towne Drugs, Inc., *Pottsville*
RxD Pharmacy of Pottsville, *Pottsville*
Bracey Pharmacy, *Ashland*
Degutis Pharmacy, Inc., *Minersville*
Siro's Pharmacy, *Schuylkill Haven*
Stine's Pharmacy, *Schuylkill Haven*
Williams Valley Pharmacy, *Tower City*
Tri-Valley Pharmacy, *Tremont, Valley View*
Standard Drug, *McAdoo*
Flamini Pharmacy, *Tamaqua*
Shafer's Pharmacy, *Tamaqua*

SNYDER COUNTY
Shade Mountain Pharmacy, *Mt. Pleasant Mills*

SOMERSET COUNTY
Yough Valley Pharmacy, *Confluence*
Findley's Pharmacy, *Somerset*
FB Thomas Drugs, Inc., *Myersdale*

SULLIVAN COUNTY
Dushore Pharmacy, *Dushore*

SUSQUEHANNA COUNTY
Red Cross Pharmacy, *Forest City*

TIOGA COUNTY
Price Pharmacy, *Wellsboro*
Lemon's Pharmacy, *Blossburg*

UNION COUNTY
ECH Homecare Pharmacy, *Lewisburg*

VENANGO COUNTY
Glenview Apothecary, *Oil City*
The Medicine Shoppe, *Franklin*

WARREN COUNTY
The Medicine Shoppe, *Warren*

WASHINGTON COUNTY
Tenth Street Pharmacy, *Charleroi*
The Medicine Shoppe, *Monongahela, Washington, Canonsburg*
Giant Eagle Pharmacy, *Washington*
Sollon Pharmacy, *Canonsburg*
Eighty-Four Pharmacy, *Eighty-Four*
Mountford Drug Store, *Houston*
Redstone Pharmacy, *California*

WAYNE COUNTY
The Medicine Shoppe, *Honesdale*

WESTMORELAND COUNTY
Health Center Pharmacy, *Monessen*
The Medicine Shoppe, *New Kensington, Irwin, Jeannette, Latrobe, Mt. Pleasant*
Professional Pharmacy, *Greensburg*
Union Prescription Center, *Greensburg*
Henefield Plaza Pharmacy, *Greensburg*
Ranier's Pharmacy, *Jeannette*
Med Systems, *Latrobe*
Hayes Pharmacy, *Ligonier*
Ligonier Pharmacy, *Ligonier*
Medicap Pharmacy, *Murrysville*
Norvelt Pharmacy, *Norvelt*
Scottdale Pharmacy, *Scottdale*
Hayden's Pharmacy, *Youngwood*

WYOMING COUNTY
Winola Pharmacy, *Lake Winola*
Lech's Pharmacy, *Meshoppen*
Rural Health Corp. Pharmacy, *Noxen*
J & J Pharmacy, *Tunkhannock*

YORK COUNTY
Gruber's Pharmacy, *Dillsburg*
East Berlin Pharmacy, *Dover*
Fairview Professional Pharmacy, *Etters*
The Medicine Shoppe, *Hanover*
Broadway Pharmacy, *Hanover*
Amcare Health Services, *York*
Weis Pharmacy, *York*
York Apothecary, *York*
Brockie Pharmacy, *York*
West York Apothecary, *York*

OBITUARIES

William C. Beck, MD, *Sayre*
Northwestern University Medical School, 1932; age 86, died August 11, 1994. Dr. Beck was a general surgeon.•

Mark A. Blatt, MD, *Bala Cynwynd*
Hahnemann University School of Medicine, 1956; age 63, died October 14, 1994. Dr. Blatt was a general practitioner.•

Daniel M. Chan, MD, *Waynesboro*
St. John's Medical School, Shanghai, China, 1957; age 60, died September 11, 1994. Dr. Chan was an anesthesiologist.•

James D. Garnet, MD, *West Chester*
Jefferson Medical College of Thomas Jefferson University, 1941; age 78, died September 10, 1994. Dr. Garnet was a gynecologist.•

Elizabeth H. Gordon, MD, *Bridgeville*
University of Pittsburgh School of Medicine, 1953; age 68, died August 8, 1994. Dr. Gordon was an obstetrician/gynecologist.•

Robert L. Hall, MD, *Newtown Square*
Hahnemann University School of Medicine, 1943; age 75, died August 19, 1994. Dr. Hall was a family practitioner.•

Charles P. Hammond, MD, *Lancaster*
Jefferson Medical College of Thomas Jefferson University, 1935; age 84, died August 30, 1994. Dr. Hammond was a general practitioner.•

James A. Heimbach, MD, *Altoona*
Hahnemann University School of Medicine, 1925; age 93, died August 30, 1994. Dr. Heimbach was an internist.•

George L. Hoffman Jr., MD, *Philadelphia*
University of Pennsylvania School of Medicine, 1936; age 82. Dr. Hoffman was an obstetrician/gynecologist.•

Glenn H. Hoffman, MD, *Mt. Gretna*
Jefferson Medical College of Thomas Jefferson University, 1954; age 66, died August 31, 1994. Dr. Hoffman was a family practitioner.•

John K. Kitzmiller, MD, *Harrisburg*
Temple University School of Medicine, 1943; age 77, died June 30, 1994. Dr. Kitzmiller was a general practitioner.•

Samuel M. Levit, MD, *Philadelphia*
Hahnemann University School of Medicine, 1939; age 81, died September 7, 1994. Dr. Levit specialized in cardiovascular diseases.•

Earl C. Marmar, MD, *Philadelphia*
Hahnemann University School of Medicine, 1973; age 46, died August 28, 1994. Dr. Marmar was an orthopedic surgeon.•

Edwin J. Medden, MD, *Bradford*
University of Rochester School of Medicine and Dentistry, New York, 1936; age 83, died September 15, 1994. Dr. Medden was a general surgeon.•

Theodore H. Mendell, MD, *Philadelphia*
Temple University School of Medicine, 1929; age 90, died September 30, 1994. Dr. Mendell was an internist.•

George E. Moerkirk, MD, *Allentown*
Temple University School of Medicine, 1948; age 68, died September 27, 1994. Dr. Moerkirk specialized in emergency medicine.•

Paul W. Neidhardt, *Denver*
Hahnemann University School of Medicine, 1953; age 67, died August 27, 1994. Dr. Neidhardt was a general practitioner.•

Leslie Nicholas, MD, *Philadelphia*
Temple University School of Medicine, 1937; age 80, died September 29, 1994. Dr. Nicholas was a dematologist.•

John N. Norris, MD, *Altoona*
Age 51; died August 28, 1994. Dr. Norris specialized in radiology.•

Thomas W. O'Connor, MD, *Mt. Joy*
Temple University School of Medicine, 1945; age 73, died September 21, 1994. Dr. O'Connor was a family practitioner.•

Fred W. Reese, MD, *Alpharetta, GA*
Temple University School of Medicine, 1943; age 77, died August 31, 1994. Dr. Reese was a general practitioner.•

William D. Reppert, MD, *Bethlehem*
Temple University School of Medicine, 1951; age 70, died September 1, 1994. Dr. Reppert was an internist.•

George J. Resnick, MD, *Philadelphia*
University Wien Med Fak, Austria, 1937; age 86, died October 5, 1994. Dr. Resnick specialized in cardiovascular diseases.•

Gabriel Schwarz, MD, *Nokomis, FL*
University of Pennsylvania School of Medicine, 1934; age 85, died September 8, 1994. Dr. Schwarz was a neurologist.•

Paul D. Shore, MD, *Drexel Hill*
University of Pennsylvania School of Medicine, 1936; age 82, died September 27, 1994. Dr. Shore was a general practitioner.•

William H. Silverman, MD, *Bethlehem*
University of Pennsylvania School of Medicine, 1929; age 90, died September 11, 1994. Dr. Silverman was a family practitioner.•

Stanley J. Skromak, MD, *Philadelphia*
Temple University School of Medicine, 1934; age 85, died September 12, 1994. Dr. Skromak was an internist.•

Frank A. Skwirut, MD, *Needhem*
Temple University School of Medicine, 1934; age 86, died September 14, 1994. Dr. Skwirut specialized in the treatment of diabetes.•

Henry W. Thomas, MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1938; age 77, died August 19, 1994. Dr. Thomas was a gynecologist.•

John S. Van Kirk Jr., MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1951; age 69, died August 22, 1994. Dr. Van Kirk was an anesthesiologist.•

Wilfred E. Vogler, MD, *Bethlehem*
Temple University School of Medicine, 1954; age 68, died September 12, 1994. Dr. Vogler was a family practitioner.•

Charletta K. Weyland Addison, MD, *Cornwall Manor*
Temple University School of Medicine, 1942; age 78, died August 20, 1994. Dr. Addison was a pediatrician.

William Bielecki, MD, *Montrose*
Med Fak Der Ludwig Maximiliams University Munchen, Bayern, Germany, 1958; age 76, died September 17, 1994. Dr. Bielecki was a psychiatrist.

Joseph M. DeVivo Sr., DO, *Philadelphia*
Chicago College of Osteopathic Medicine, 1957; age 62, died October 3, 1994. Dr. DeVivo was a urologist.

Herbert K. Goff, MD, *Greensburg*
Hahnemann University School of Medicine, 1940; age 80, died August 16, 1994. Dr. Goff was an internist.

Charles T. Osterloh, MD, *Pittsburgh*
University of Pittsburgh School of Medicine, 1942; age 77, died October 2, 1994. Dr. Osterloh was a general practitioner.

Morton Ward, MD, *Mt. Laurel, NJ*
Temple University School of Medicine, 1940; age 80, died August 8, 1994. Dr. Ward was an internist.

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NEW MEMBERS

Karin E. Evan, MD, Otolaryngology, 3400 Spruce St., 5th Flr., Ravdi, Philadelphia 19104, 215-349-5382
Olutope O. Fakiyesi, MD, Psychiatry, 5450 Wissahickon Ave., Apt. #853, Philadelphia 19144, 215-848-4169
Jacqueline M. Goldberg, MD, Ob/Gyn, 844 N. 29th St., Apt. G, Philadelphia 19130, 215-232-2432
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Peter W. Kim, MD, Internal Med., 4041 Ridge Ave., Bldg. 5, Apt. #10, Philadelphia 19129, 215-438-4989
Ramesh Koneru, MD, Psychiatry, 2991 School House Ln., Apt. #E-21, Philadelphia 19144, 215-849-5630
Constantine E. Kosmas, MD, Cardiovascular Diseases, 221-K S. MacDade Blvd., Glenolden 19036, 610-586-5274
Natalia Kovtun, MD, Internal Med., 117 N. 15th St., Apt. #906, Phildelphia 19102, 215-557-7193
Keith A. Lafferty, MD, Emergency Med., 7336 Ryers Ave., Philadelphia 19111, 215-742-5542
Deborah S. Lippman, MD, Anesthesiology, 7 E. Langhorne Ave., Havertown 19083, 610-446-8060
Cesar G. Machado, MD, 701 Summit Ave., Apt. #D-217, Philadelphia 19128, 215-482-3683
Karyn C. Markley, MD, Ob/Gyn, Pennsylvania Hosp., 800 Spruce St., Philadelphia 19107
Lesbia Mendez Irizarry, MD, Internal Med., 6635 McCallum St., Philadelphia 19119
Andrew L. Mermelstein, MD, Internal Med., 201 S. 18th St., Apt. #1613, Philadelphia 19103, 215-731-1807
Jeffrey S. Meyers, MD, Physical Med./Rehab., 101 S. Princeton Ave., Apt. #3-B, Swarthmore 19081
Alan Micklin, MD, Cardiovascular Diseases, 1 Lavister Dr., Mt. Laurel, NJ 08054, 609-778-7680
Eduardo D. Moraes, MD, Internal Med., 619 W. Hotter, Philadelphia 19119, 215-848-6170
Joseph C. Munafo III, MD, Emergency Med., 306 Cherry St., Apt. #4, Philadelphia 19106, 215-925-1417
Todd I. Murray, MD, Emergency Med., 2519 Brown St., Apt. #3, Philadelphia 19130, 215-236-4191
Mohamado S. Musthaq, MD, Psychiatry, 7841 Ridge Ave., Philadelphia 19128, 215-482-6524
Robert B. Nemerofsky, MD, 6 Pear Tree Ln., Lafayette Hill 19444, 610-825-3399
Shijun Pan, MD, 7390 Barnes St., Apt. #A-19, Philadelphia 19111, 215-340-0927
Anthony Perre, MD, Internal Med., 129 E. Moreland Ave., Philadelphia 19118, 215-247-5052
Narsimha R. Pinninti, MD, Psychiatry, 3327 Bowman St., Philadelphia 19129
Sharon R. Popik, MD, Internal Med., 2601 Pennsylvania Ave., Apt. #92, Philadelphia 19130, 215-232-4231
Maria F. Rodriguez, MD, Psychiatry, Alden Park Apts., 2979 Schoolhouse Ln., Apt. #212-K, Philadelphia 19144, 215-849-7147
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Next Month in PENNSYLVANIA MEDICINE

Look for a recap of 1994 legislation addressing such issues as:

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With Friends Like These...

Lee H. McCormick, MD

Editor's note: This article was originally published in the Allegheny County Medical Society Bulletin, then reworked for the AMA Hospital Medical Staff Section's monthly news insert featured in the Medical Staff and Physician Organization Legal Advisor. This is excepted from the AMA-HMSS version.

Two years ago at an AMA Hospital Medical Staff Section (HMSS) Governing Council luncheon, Dick Davidson, president of the American Hospital Association (AHA), explained AHA's grand vision for the health care system of the future. He described a plan for physicians and hospitals to work together as partners. Recognizing skepticism by the Governing Council, he asked that prior differences be set aside, and assured everyone that physicians and hospitals truly could be equal partners in community care networks.

Physicians across the country began talking to their hospitals about various forms of integration. Medical staffs and hospital administrators explored ways in which their organizations could cooperate for mutual benefit. They forgot previous problems and disagreements. It appeared that, at long last, physicians and hospitals could work together as partners.

It kinda makes you feel all warm and fuzzy, doesn't it? Well forget it! If it is warm and fuzzy you want, find a teddy bear, not a hospital!

The AMA, as part of its health system reform efforts, developed legislation that was introduced into Congress as the Hatch-Archer bill. The bill, which AHA helped to structure, changes current antitrust laws that prevent physicians from collectively forming networks and, in fact, facilitates network formation by *all* providers, including hospitals.

But, on June 16, 1994, AHA Executive Rick Pollack wrote to Senators Moynihan, Kennedy, Metzenbaum, Congressmen Gibbons and Brooks, and the entire Senate Finance Committee, strongly opposing antitrust exemptions for physicians, characterizing them as "unnecessary and potentially dangerous." He said, "Rather than advocating the adoption of statutory exemptions, AHA seeks an essential examination and clarification of antitrust policies in order to encourage and facilitate development of integrated multi-provider networks." He added that "AHA will not support legislative proposals to grant blanket immunity to providers whose activities have no or very limited potential for efficiencies...particularly where exemptions could result in increased health care costs and foster fragmentation of health care delivery."

James S. Todd, MD, executive vice president of the AMA, followed with a letter to Senator Moynihan, pointing out that AMA and AHA part company on the issue of whether reforms should facilitate the development of networks by a multitude of providers or by a single group, and that it is increasingly apparent that hospitals want to control networks without competition from physicians. An article from the June 13, 1994, edition of the *Washington Post* was quoted as saying that "hospitals are trying to get control over physicians and the physicians' revenue stream before becoming completely obsolete."

I, too, expressed my concern about AHA's position by writing, on behalf of the AMA-HMSS, to Mr. Davidson. In a July 29 reply, he reaffirmed AHA's opposition to the Hatch-Archer bill and stated that "while we have identified antitrust concerns that need to be addressed, AHA does not view broad statutory exemptions from the antitrust laws as necessary or appropriate for development of integrated delivery system." Since AHA continues to pursue antitrust reforms that would facilitate the formation of hospital networks, we can assume that the "antitrust concerns that need to be adressed" are those that only favor hospitals, *not* physicians.

What does this mean for medical staff physicians? Consider the following: 1) Virtually every hospital in the country has formed, is forming, or plans to form a physician hospital organization (PHO); 2) PHOs are business organizations; and 3) Do you want a business partner who is motivated by self-interest? Remember that hospitals need physicians more than physicians need hospitals.

If you are involved in the formation of a PHO, I offer these suggestions: Ask your hospital administrator if they support AHA's position opposing antitrust reform for physicians. If they do not agree with the position, ask if they are willing to write to AHA voicing their opposition, and send a copy of the letter to the AMA-HMSS. If they won't oppose AHA's position, draw your own conclusions.

AHA has implied that they want to be friends with physicians. With friends like these, who needs enemies?

Dr. McCormick, a Pittsburgh physician specializing in the treatment of substance abuse, is chair of the AMA's Hospital Medical Staff Section and a member of the State Society's Board of Trustees.

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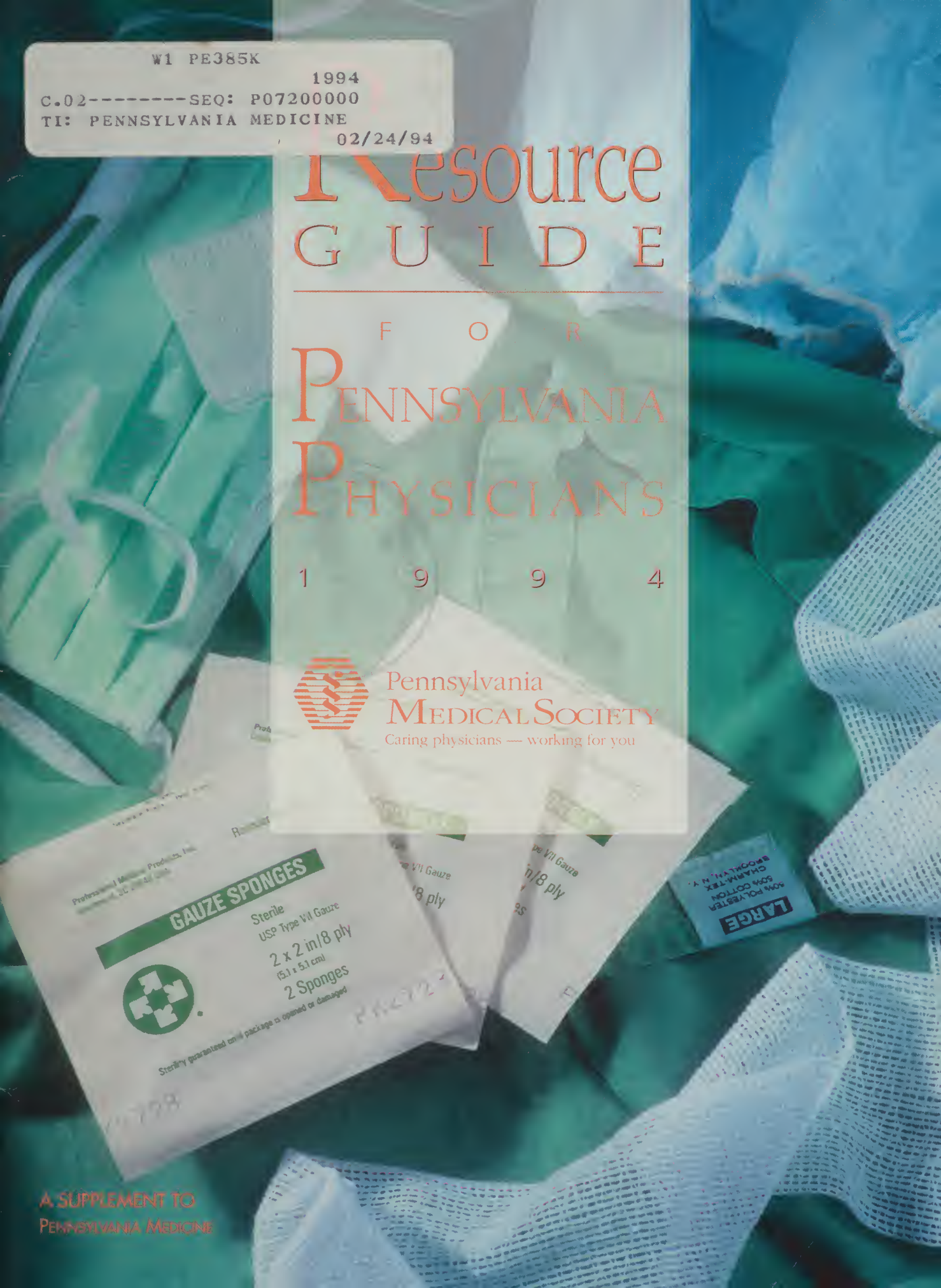

A SUPPLEMENT TO
PENNSYLVANIA MEDICINE

About this guide ...

This time of change in our nation's health care delivery system is a period of critical importance to physicians and their patients. It is a time when there is a greater need than ever for two-way communication between members and the organization which seeks to represent their interests and serve their practice and personal needs.

The third annual **Resource Guide for Pennsylvania Physicians** *is one way that the Pennsylvania Medical Society is working to make it as easy as possible for member physicians to take full advantage of the many services and resources the Society offers.*

This 1994 guide is a single-source reference book provided free of charge to the Society's 21,000 members.

It includes a directory of the many physicians throughout the commonwealth who serve on the councils, committees, and special sections conducting Society business at the direction of the House of Delegates.

You also can use this guide to order Society-developed products and services available free of charge or at discounted prices to members.

The guide provides the information you need to reach the Society's subsidiaries and related organizations — the Pennsylvania Medical Society Liability Insurance Company (PMSLIC), the Keystone Peer Review Organization (KePRO), The Educational and Scientific Trust, the Pennsylvania Medical Society Alliance, and the Pennsylvania Medical Society's Political Action Committee (PAMPAC).

It also includes Society administrative departments and staff, and a handy directory of important telephone numbers.

Keep this guide as a convenient reference and reminder of the many resources available to you through your State Society. But remember that your Society is continually seeking new ways to serve your interests in this time of change and challenge.

Use the Society's toll-free number for help or for information about new resources that may not appear in this guide:

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Health System Reform Materials!

In addition to our featured products, health system reform materials are available. Call the Department of Communications at 1-800-228-7823 for more information.

Products
AND SERVICES

How to Order:
See order insert
or call 1 (800) 228-7823

NEW!

Managed Care!

◂Managed Care Resource Kit

The Resource Kit is designed to select and condense important managed care information presently offered to physicians from sources throughout the country. The kit will include: a bibliography of articles published on issues related to managed care; reprinted articles selected from the bibliography, as well as information on how to order other articles; a managed care contract checklist; names, addresses, and telephone numbers of HMOs and PPOs in Pennsylvania; the Society's managed care position paper; information on publications and seminars available from large specialty groups; a brochure outlining available AMA publications; and other selected resources.
Free to members; Not available to non-members *Order #* **PSMCK26**

PRACTICE MANAGEMENT

UPDATED!

◂Laws and Regulations Affecting Medical Practice

A 47-chapter reference for Pennsylvania physicians on their legal rights and responsibilities associated with abortion, antitrust, motor vehicle code reporting, medical records, delegation of duties to nonphysician practitioners, corporate practice of medicine, licensure, withholding life support, and many other issues impacting medical practices. All PMSLIC insureds are provided with a complimentary copy.as a policy holder service.
Member price: $65 *Non-member price: $130* Order # **PSLAR11**

Managed Care!

NEW!

▲Managed Care Handbook

A valuable practice management tool based on actual case studies of what works and what does not when dealing with managed care. Some of the key issues covered include getting your money from managed care organizations; managing patient certification; reorganizing to improve compensation and address scheduling, staffing and delegating; and how to pre-determine revenues to ensure profitable participation decisions. This highly practical handbook is published by Conomikes Associates, leading experts in medical practice management since 1970.
Member price: $69
Nonmember price: $89
Order # **PSMCH27**

▸A Physician's Guide to Employment Contracts

A 74-page comprehensive manual to assist physicians in understanding, discussing, and negotiating balanced employment contracts with various health care providers. Covers anti-trust considerations, liability issues, arrangements for assignment accounts, and restrictive covenants. The guide also reviews and discusses contract language in both employment and independent contractor arrangements.
Member price: $40 *Non-member price: $60*
Order # **PSECG12**

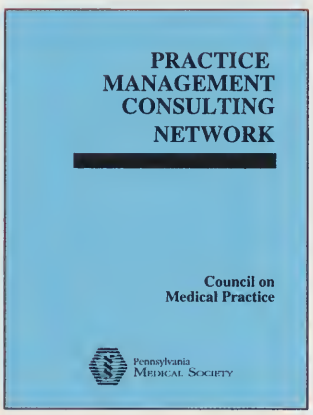
UPDATED!

Products AND SERVICES

How to Order:
See order insert
or call 1 (800) 228-7823

▸ Medical Office Staff Handbook
A comprehensive, 110-page manual focusing on three areas of concern in many practices: telephone procedures, appointment scheduling and patient service. After completing the 19 handbook worksheets, physicians and staff will have a customized procedure manual for the office.
Member price: $69 *Non-member price: $89*
Order # **PSMOH13**

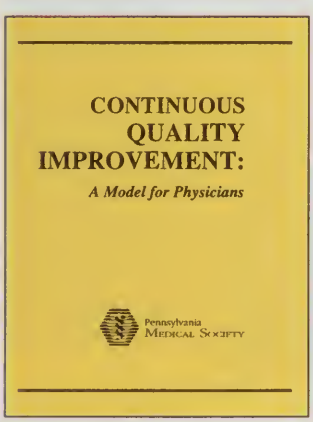
Marketing Guide for Physicians: Second Edition
A 30-page handbook explaining marketing concepts for medical practice. *Free to members*
Non-member price: $6.50
Order # **PSMKG17**



◂ Practice Management Consulting Network
A brief listing of physician-recommended Pennsylvania consulting firms qualified to assist physicians with practice management, reimbursement and financial planning.
Free to members
Non-member price: $5
Order # **PSPCN18**

◂ Patient Satisfaction Questionnaire
Survey your practice to collect patient demographic data and valuable practice marketing guidance. Minimum order of 400 questionnaires includes guidelines for analyzing data.
Member price: $40; $10 per additional 100.
Non-member price: $60; $15 per additional 100.
Order # **PSPSQ14**

◂ Physicians' Guide to Purchasing Professional and Personal Insurance
A manual offering concise and "jargon-free" explanation of the types of insurance available to physicians, how to evaluate and decide on the proper amounts of coverage, and what questions to ask insurance agents about policies. *Member price: $30*
Non-member price: $50 Order # **PSPPI16**



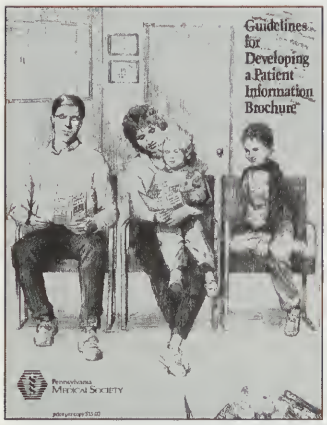
◂ Continuous Quality Improvement: A Model for Physicians
This manual is a concise and practical exploration of how Total Quality Management (TQM) applies to healthcare delivery. *Free to members*
Not available to nonmembers
Order # **PSTQM28**

OSHA Information Kit
Includes all necessary documentation to comply with the regulations: OSHA Final Regulations Overview; Employee Training Manual; Model Exposure Control Plan; and a copy of the regulations. *Member price: $10*
Not available to non-members Order # **PSOSH20**

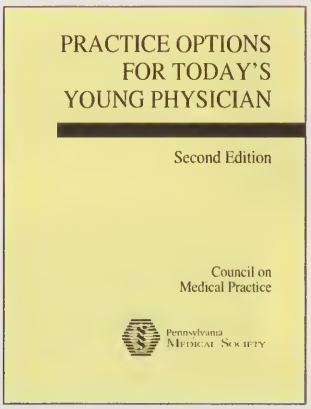
Products AND SERVICES

How to Order:
See order insert
or call 1 (800) 228-7823

Practice Management



▲ Guidelines for Developing a Patient Information Brochure
A 14-page handbook providing step-by-step instructions for developing a patient information brochure.
Free to members
Non-member price: $15
Order # **PSP1B10**



◄ Practice Options for Today's Young Physician
A summary of practice alternatives—solo, group, research, administrative, or established—for physicians completing residency. *Free to members.*
Non-member price: $15
Order # **PSPRO15**

Directory of Physician Executives in Pennsylvania
Free to members; Non-member price: $10
Non-physician Price: $110 Order # **PSDPE21**

Planning Your Retirement—Second Edition
Free to members; Non-member price: $19.50
Order # **PSPFR22**

Service

Magazine Subscription Service
Magazine subscriptions at lowest rates available and automatically extends/renews existing subscriptions. For information contact: 1(800) 289-6247

◄ Pennsylvania Medical Society MasterCard

Pennsylvania Medical Society MasterCard
A Gold MasterCard with individually established credit lines—up to $50,000—is available through MBNA Bank, N.A. No annual fee for the first year. Annual fee is waived in subsequent years if charges exceed $3,500. A BusinessCard is also available. Call 1 (800) 847-7378, ext. 5000 to apply.

► Physician Data Package

Get the Physician Data Package and get the facts about the physician population in Pennsylvania. Each package contains 4 separate reports: total MDs and DOs; active MDs and DOs by county; active MD and DO population ratios by county; and active MDs and DOs segmented by age, sex and county. Also available are custom-designed data reports and mailing labels. Call: 1(800) 228-7823, ext. 284 to order. *Member Standard Data Package price: $50*
Nonmember Standard Data Package price: $150
All other users: $250

NEW!

▲ Employment Law Manual for Physicians
An interpretation of all major state and federal laws relating to employment, including: wages and overtime, employment discrimination, employment termination and employment-at-will, workplace privacy, employee benefits, health and safety, unions, employer record keeping, and employer notice/posting requirements. Will include practical advice and suggestions for implementing the laws. Annual updates will be offered.
Member price: $50, *Non-member price: $75,*
Non-physician price: $100 Order # **PSELM29**

Products
AND SERVICES

How to Order:
See order insert
or call 1 (800) 228-7823

MEDICAL STAFF ASSISTANCE

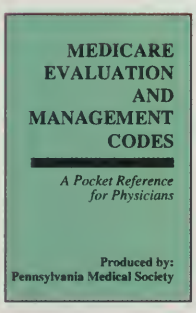
EXPANDED SERVICES!

▲ Medical Staff Legal Service Plan
Legal services are provided to medical staffs on a prepaid or group discount basis. Available services include: bylaws review; general legal services associated with the formation of IPOs, PHOs, and other types of joint ventures, and telephone inquiry service. For more details, or to receive a brochure, call the Department of Physician Services at: 1 (800) 228-7823.

◄ Medical Staff Handbook: Volumes I & II
Volume I: A 156-page handbook designed to assist medical staff leaders in dealing with issues such as: developing or revising bylaws to comply with licensure and accreditation requirements and protect medical staff self-governance; identifying medical staff rights and responsibilities in delivery of quality care; maintaining confidentiality. *Member price: $40. Non-member price: $60.* Also available on computer disk: 1.2 Meg 5" or 360 KB 5" floppy disk—*Member price $125; non-member price $175.*
(Volume II is currently being developed.)
Order # **PSMSH23**

PHYSICIAN REIMBURSEMENT

For questions or assistance with Physician Reimbursement call toll free 1 (800) 228-7823



▲ Medicare Evaluation and Management Codes—A Pocket Reference
Free to members. Non-member price: $5
Order # **PSPSR24**

► Comparison of Practice Management Software
Includes: (1) a selection of software products available for physicians; (2) hardware options and pricing; (3) definitions of software and hardware terminology; and (4) explanation on how to select software and hardware.
Free to members; Non-member price: $35
Non-physician price: $50 Order # **PSPMS25**

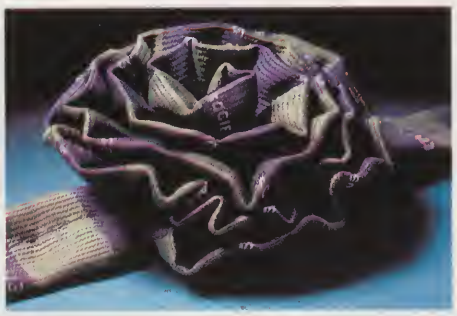
Pennsylvania Blue Shield Audit & Review Procedures
A handbook explaining Blue Shield private business insurance audit procedures. *Free to members* *Non-member price: $15*
Order # **PSPBS19**

Electronic Claims Filing Service
Designed to take the hassle out of electronic claims submission. This service connects physicians to all major insurance companies accepting claims electronically. No long distance charges. No complicated modems. No need to learn telecommunications. No start-up fees. No monthly minimums for claim submission volume. For more information call Physicians Practice Management (PPM) at: 1 (800) 428-3515

Products
AND SERVICES

How to Order:
See order insert
or call 1 (800) 228-7823

The Educational and Scientific Trust



◄Women's ties
Available as women's bow tie or as rosette; both styles available in navy & green; navy & tan; *rosette not available in navy & maroon.*
Bow Tie Order # **EST23**
Rosette Order # **EST24**
$15 each

▲ Men's ties
Available as neck tie or men's bow tie; both styles available in navy & green; navy & tan; *bow ties not available in navy & maroon .*
Bow Tie Order # **EST15**
Neck Tie Order # **EST16**
$15 each

►Men's sport shirts
Colors available: navy, white, emerald, red
Sizes: small **(EST28)**, medium **(EST29)**, large **(EST30)**, extra large **(EST31)**, extra-extra large **(EST32)**
$30 each

►Women's sport shirts
Colors available: navy, white, aquarium, red
Sizes: small **(EST33)**, medium **(EST34)**, large **(EST35)**, extra large **(EST36)**
$30 each

●Handkerchiefs
Navy and maroon
$10 each Order # **EST18**

●Certificate frames
Available in black or walnut finish.
$15.90 each Order # **EST17**

◄Pewter tie/lapel pins
$12.75 each
Order # **EST37**

Communicating With Patients

►Pennsylvania Medicine
The monthly publication of the Pennsylvania Medical Society, free to all members, features articles exploring many aspects of today's practice of medicine: legislative news; colleagues' achievements; regulatory analysis; public health guidelines; reimbursement and medical economics advice; messages on controversial issues from physician leaders. The August issue is the official Directory of the State Society's membership.
Use of the classified and display advertising portions to contact 20,000 physicians every month with your business needs. Pennsylvania Medicine is designed to inform, as well as to serve, Pennsylvania physicians.

◄Communications
Whether communicating with your patients, speaking in your community, or contacting legislators or colleagues, the State Society's Division of Communications and Public Affairs is there to help. Contact the Division for a complete list of free materials. Some items currently available include:

- **Public Opinion Survey**—Pennsylvanians' opinions on bioethical and health care reform issues.
- **Dignity in Death/Dignity in Dying**—a complete guide to writing a "living will"; includes an actual will and wallet card. First 100 free to each member; additional by special order.
- **Seat Belt Safety**—tips for parents on use of children's car seats.
- **Youth Against Tobacco**—materials to encourage youths to avoid tobacco use and join the campaign against smoking
- **Sample speeches**—draft of texts you can use if speaking before community groups.

Products AND SERVICES

Pennsylvania Medical Society Endorsed Insurance Products

Pennsylvania Medical Society Liability Insurance company 1 (800) 445-1212

Throughout its 16-year history, PMSLIC has set its course with the guidance and the counsel of physicians. This peer governance sharply distinguishes the company from other carriers in Pennsylvania. Because of its dedication to controlling the professional liability problem, rather than reacting to it, PMSLIC has positioned itself to continue to be the leader in serving Pennsylvania physicians in their professional liability insurance needs. If you are not currently a PMSLIC insured, contact the company at 1 (800) 445-1212 and ask a Policyholders Service Representative how PMSLIC may better serve you and your practice.

Risk Management

Medical-Legal Correspondence Course
A course providing basic information on how to practice safer, more defensible medicine. Upon completion, 12 hours of continuing medical education credit are awarded.
Member price: $125 Order # **RMMLC27**

Patient Rx Newsletter
A bi-monthly newsletter on current litigation trends and risk management issues affecting medical practice.
Order # **RMPRN28**

Patient Telephone Call Record Pads
Member price: 10 pads: $12.72; 20 pads: $25.44
Order # **RMTCR29**

Consult
A two-page home-study publication distributed quarterly to all Society members that addresses a variety of medical-legal topics. *Member Price: No Charge* Order # **RMCON30**

Physician's Medical Legal Guide for the Office
A practical reference for physicians and office staff. Includes legal requirements for medical records, confidentiality, informed consent, and termination of physician-patient relationship, and more. A 30-minute audiotape on risk management for office staff is also available.
Member Price: No Charge Order # **RMMLG31**

To order by phone call: 1 (800) 445-1212

Additional Society Endorsed Insurance

- ►Medical Insurance—the Society offers a Blue Cross/Blue Shield plan to members, eligible dependents, and employees (Plans not available in all areas)
- ►Individual Disability Income Insurance
- ►Individual Term Life Insurance
- ►Nursing Home/Home Health Care
- ►Long Term Disability/Group Term Life
- ►Business Overhead Expense
- ►Office and Property Contents
- ►Additional Coverages

For information on the above services contact Bertholon-Rowland at 1 (800) 551-4504 in Eastern Pennsylvania or Dexter-Bertholon-Rowland at 1 (800) 327-1550 in Western Pennsylvania.

- ►Workers' compensation insurance—competitive rates with low minimum payroll requirements.

For information on the above insurance call the Dodson Group at 1 (800) 825-3760 Ext. 2990.

See page 5 for information about "A Physician's Guide to Purchasing Professional and Personal Insurance."

Seminar SCHEDULE 1994

Additional seminars may be scheduled. Please call the Department of Physician Services for the latest information. 1 (800) 228-7823

March

"How to Get Started in Medical Practice"
(Conomikes)

March 8 Pittsburgh—Allegheny County Medical Society
March 9 Harrisburg—State Society Headquarters
March 10 Philadelphia—Philadelphia County Medical Society

"Managed Care in Pennsylvania— What Physicians Can Do to Influence the Outcome or Design of the New System"
(Pennsylvania Medical Society Consulting Company and KPMG Peat Marwick)
Tentative Dates—call for more information

March 15 Pittsburgh
March 16 Harrisburg
March 17 King of Prussia

April

"How to Run a More Profitable Practice"
(Conomikes)

April 5 Pittsburgh—Greentree Marriott
April 6 Harrisburg—Medical Society Headquarters
April 7 Philadelphia—Sheraton Northeast

May

"ICD-9 Coding"

May 3 Pittsburgh—Sheraton Station Square
May 4 Harrisburg—State Society Headquarters
May 5 Philadelphia—Sheraton Inn Northeast

"Employment Law and Employee Benefits"
(Reed Smith Shaw & McClay)

May 17 Pittsburgh
May 19 Harrisburg
May 24 King of Prussia

June

"Medical Office Management Institute" (MOMI)
(Conomikes)
"Effective Personnel Management Techniques and Improving Managerial Effectiveness"
"Basic Coding Workshop"
"Patient Flow Management"
"Financial Management"

June 7, 8, 9, 10 Pittsburgh
June 14, 15, 16, 17 King of Prussia

September/October

"Advanced Managed Care Management and Physician Integration"
(Pennsylvania Medical Society Consulting Company and KPMG Peat Marwick)
Dates in September and locations to be announced.

"Practice Exit Planning: How to Get the Best Value For Your Practice"
(The Health Care Group and Health Care Law Associates)

September 24 Pittsburgh
October 1 King of Prussia
October 8 Harrisburg

"How to Get Started in Medical Practice"
(Conomikes)

October 4 Pittsburgh—Allegheny County Medical Society
October 5 Harrisburg—State Society Headquarters
October 6 Philadelphia—Philadelphia County Medical Society

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Officials

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Headquarters Office
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Harrisburg, PA 17105-8820
(717) 558-7750
1-800-228-7823

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Greensburg 15601
(412) 837-4070

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Easton 18042
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Easton 18042
(610) 252-2556

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Harrisburg 17105-8820
(717) 558-7750

Trustees

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Chair

Victor F. Greco, MD
Vice Chair

▸ *First District*
George R. Fisher III, MD
829 Spruce St.
Suite 308
Philadelphia 19107
(215) 922-5252. Term expires 1995. Philadelphia County.

▸ *Second District*
John W. Lawrence, MD
1078 W. Baltimore Pike
Media 19063
(610) 566-4311. Term expires 1996. Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery counties.

▸ *Third District*
John J. McAndrew, MD
319 N. Abington Rd.
Clarks Green 18411
(717) 587-3070. Term expires 1995. Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne counties.

▸ *Fourth District*
Frederick G. Brown, MD
Geisinger Medical Center
Danville 17822
(717) 271-6393. Term expires 1996. Columbia, Montour, Northumberland, Schuylkill, and Snyder counties.

▸ *Fifth District*
Herbert C. Perlman, MD
1104 Fleetwood Dr.
Carlisle 17013
(717) 245-5400. Term expires 1996. Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York counties.

▸ *Sixth District*
Edward H. Dench Jr., MD
945 Outer Dr.
State College 16801
(814) 466-7975. Term expires 1994. Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin counties.

▸ *Seventh District*
William R. Beltz, MD
699 Rural Ave.
Williamsport 17701
(717) 326-4007. Term expires 1994. Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union counties.

▸ *Eighth District*
Robert L. Lasher, MD
217 Indiana Dr.
Erie 16505
(814) 455-5114. Term expires 1995. Crawford, Erie, Forest, McKean, Mercer, and Warren counties.

▸ *Ninth District*
John W. Mills, MD
590 Indian Springs Rd.
Indiana 15701
(412) 349-2691/349-1203 (recorded message only). Term expires 1995. Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.

▸ *Tenth District*
John W. Lehman, MD
1415 Sixth Ave.
P.O. Box 816
Beaver Falls 15010
(412) 843-7812. Term expires 1994. Beaver, Lawrence, and Westmoreland counties.

▸ *Eleventh District*
Ferdinand L. Soisson Jr., MD
East Hills Professional Bldg.
1450 Scalp Ave., Suite 101
Johnstown 15904
(814) 269-2270. Term expires 1996. Bedford, Cambria, Fayette, Greene, Somerset, and Washington counties.

▸ *Twelfth District*
Victor F. Greco, MD
E-Z Acres
RR 4, Box 4404
Drums 18222
(717) 788-3225. Term expires 1994. Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties.

▸ *Thirteenth District*
Carol E. Rose, MD
428 Glaids Dr.
Pittsburgh 15243
(412) 647-6726. Term expires 1995. Allegheny County.

▸ *Hospital Medical Staff Section*
Lee H. McCormick, MD
2708 Brownsville Rd.
Pittsburgh 15227
(412) 885-6330. Term expires 1995.

▶ *Interspecialty Section*
James R. Regan, MD
3222 Green Meadow Dr.
Bethlehem 18017
(610) 691-2282. Term expires 1994.

Medical Students Section
Stacy L. Krisher
331 Devonshire St., Apt. D-7
Pittsburgh 15213
(412) 683-3050. Term expires 1994 (or upon completion of medical school).

▶ *Resident Physician Section*
Joyann A. Kroser, MD
7901 Henry Ave., Apt. A507
Philadelphia 19128
(215) 483-7159. Term expires 1995 (or upon completion of residency).

▶ *Young Physician Section*
John R. Martell Jr., MD
Allegheny Prof. Bldg.
490 E. North Ave.
Suite 400
Pittsburgh 15212
(412) 322-4850. Term Expires 1994.

▶ *Voting members of the Board of Trustees*

Society Staff Field Contact Representatives

First and Second Districts
Stacy M. Wenger

Third District
Linda L. Koval

Fourth District
Debora B. Faesel

Fifth District
Megan E. Neuhard

Sixth District
Robert J. Lilley

Seventh District
Sharon R. Orlowski

Eighth District
Larry L. Light

Ninth District
Frances A. Battista

Tenth District
Richard R. Orlandi

Eleventh District
David J. Thompson

Twelfth District
Lisa M. Dugan

Thirteenth District
Amy K. Dugan

Judicial Council

Judicial power of the Society is vested in this council. Its decisions are considered final subject to the right of appeal to the Judicial Council of the American Medical Association. The council considers such matters as rights or standing of members, controversies falling under the Society's bylaws, or principles of medical ethics and controversies between two or more component societies or their members.

Raymond C. Grandon, MD
131 State St.
Harrisburg 17101
(717) 234-4187
(Term expires 1994)

Betty L. Cottle, MD
25 Sylvan Dr.
Hollidaysburg 16648
(814) 695-0659
(Term expires 1995)

David W. Clare, MD
577 Briar Cliff Rd.
Pittsburgh 15221-3218
(412) 623-2717
(Term expires 1994)

Henry H. Fetterman, MD
501 N. 17th St.
Allentown 18104-5044
(215) 435-8562
(Term expires 1996)

Jonathan E. Rhoads Sr., MD
3400 Spruce St.
Philadelphia 19104
(215) 662-2008
(Term expires 1996)

Staff Assignment
Kenneth B. Jones Esq.

Address inquiries to
Ferdinand L. Soisson Jr., MD
Judicial Council Secretary
777 E. Park Dr.
P.O. Box 8820
Harrisburg 17105-8820

Pennsylvania Delegation to the American Medical Association

Delegates Whose Terms Expire 1994

R. William Alexander, MD
544 Elm St.
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(610) 374-4951

Richard D. Baltz, MD
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Camp Hill 17011
(717) 737-7100

Doris G. Bartuska, MD
3227 W. Penn St.
Philadelphia 19129
(215) 842-6952

Joseph B. Blood Jr., MD
Guthrie Clinic, Guthrie Sq.
Sayre 18840
(717) 882-3109

Betty L. Cottle, MD
25 Sylvan Dr.
Hollidaysburg 16648
(814) 695-0659

James B. Donaldson, MD
10 Summit Dr.
Bryn Mawr 19010
(610) 525-5420

Victor F. Greco, MD
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Drums 18222
(717) 788-3225

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Pittsburgh 15227
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John S. Parker, MD
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Latrobe 15650
(412) 539-3555

Howard A. Richter, MD
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Wynnewood 19096
(610) 649-4416

Roberta L. Schneider, MD
5250 Silo Hill Rd.
Doylestown 18901
(609) 987-5986

Donald H. Smith, MD
1901 Hay Terrace
Easton 18042
(610) 252-2556

Delegates Whose Terms Expire 1995

Donald C. Brown, MD
Irwin Prof. Ctr.
100 Pennsylvania Ave.
Irwin 15642
(412) 864-5759

Member Alert:

Your State Society is spearheading efforts on your behalf to influence the direction of health system reform in Pennsylvania.

Ronald J. Clearfield, MD
Citizens General Hosp.
651 Fourth Ave.
New Kensington 15068
(412) 337-3541

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Committees–Board of Trustees

Standing Committees

Executive
Exercises all rights and duties of the Board between meetings of the Board; serves as the Advisory Committee to the Society Alliance; and engages in such other activities as the Board of Trustees may designate.

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Finance

The Committee reviews proposed programs or projects as they occur during the year and presents the Board with cost estimates and advises on availability of funds before the Board acts on these. The Committee also regularly reviews the Pennsylvania Medical Society investment portfolio. The Committee annually reviews with the auditors the audited financial statement, internal checks and balances, and operating and accounting procedures. The Finance Committee presents the annual budget of the Society to the Board.

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Staff Assignment
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Publication

Supervises the publication of Pennsylvania Medicine, *establishes advertising rates, and reviews editorial policies consistent with goals set for the publication by the Board of Trustees.*

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Staff Assignment
Elaine Herrmann

Permanent Committees

Distinguished Service Award

Periodically recommends members who have made outstanding contributions to the medical profession for the Society's Distinguished Service Award (the highest honor the Society can bestow on a physician). Annually solicits and reviews candidates for the Society's Physician Volunteer Award and various AMA awards.

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KePRO Oversight

Assesses impact of KePRO on health care system in Commonwealth and effect of KePRO on Society members. Acts as fact finder relative to member complaints.

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Staff Assignment
Debora B. Faesel

Member Alert:

What is your Society emphasizing as essential to reform?

- ***Freedom of choice***
- ***Preserving quality***
- ***Patient advocacy***
- ***Liability tort reform***
- ***Protecting innovation and technology***
- ***Minimizing bureaucracy and paperwork***

Management Advisory

Confers with Executive Vice President on administrative matters which require review or counsel. Hears individual trustee/officer complaints against staff when the response of the Executive Vice President is considered unsatisfactory.

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Nominate Members to KePRO Board

Presents nominations to the Society Board for appointment to the Board of Keystone Peer Review Organization. Reviews the performance of incumbents and seeks counsel from the president of KePRO.

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Nominate Members to PMSLIC Board

Presents nominations to the Society Board for appointment to the Board of the Pennsylvania Medical Society Liability Insurance Company. Reviews performance of incumbents and seeks counsel from the Chair of the Board of PMSLIC.

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Staff Assignment
Arnold W. Cushner

Organization and Operation of the Board

Recommends rules for the organization and procedures of the Board. Convenes annually in advance of the Board's reorganization meeting to consider continuation, discharge, or reconstitution of Board committees not mandated by the bylaws and to make recommendations to the Board.

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Staff Assignment
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Professional Liability Insurance Appeals

Under a formal written agreement with PMSLIC, this committee provides a mechanism for Society members insured by PMSLIC to appeal underwriting actions or decisions. The findings of the committee are binding on PMSLIC.

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Staff Assignment
Richard R. Orlandi

Spring Assembly

Develops agenda and program for annual conference dedicated to professional development of members.

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Staff Assignment
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Ad Hoc Committees

Ad hoc committees are appointed to complete a specific task. They have a life of one year and are dissolved on completion of their task or at the end of a year unless reappointed.

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Member Alert:

Your State Society is implementing a multi-stage plan to assess potential for involvement in managed care organizations for Pennsylvania physicians.

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Committees–State Society

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Aid to Education
Encourages members to contribute to loan and scholarship funds of the Educational and Scientific Trust of the Pennsylvania Medical Society and of the component societies and upon request from the AMA, to the educational and research programs and funds of that organization.

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Executive Vice President
Roger F. Mecum

Staff Assignment
Kay A. Barrett

Medical Benevolence
The Medical Benevolence Fund is to be used only for payment of funds to members and immediate family of deceased members in financial distress or for other charitable uses. The Medical Benevolence Committee approves the criteria for making payments and provides broad oversight of The Educational and Scientific Trust, which is the custodian and administrator of the fund.

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Administrative Councils

Council on Education and Science

Monitors Society policy on medical schools, continuing medical education, State Board of Medicine, allied health professionals, bioethics, public health, environmental and occupational health, and medical science issues.

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Commission on Bioethics

Studies questions of advance directives, moral conflicts, quality of life, termination of care, and serves as liaison to institutional ethics committees.

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Compare selected practice management computer software and hardware more easily with the Society's analysis of selected vendors.

(see page 7)

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Member Alert:

Your Society represents you as part of numerous coalitions and alliances statewide dealing with public health crises and concerns.

Member Alert:

Need information to help you understand and anticipate health system reform on the state and national levels? Call the Communications and Public Affairs Division for free materials.

1-800-228-7823

Member Alert:

Have a reimbursement question? Call your State Society Department of Medical Economics. Our experts are on-call to help you.

1-800-228-7823

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Claudia A. Henry, *administrative secretary*

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Linda L. Koval, *assistant director*

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Gwendolyn P. Yackee, *executive director, Psychiatric Physicians of Pennsylvania*

Kathy A. York, *account manager*

Patricia M. Bogatay, *executive director, Pittsburgh Psychiatric Society*

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Linda M. Hare, *meeting manager*

Jeanmarie Staufenberg, *meeting manager*

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Crystal M. Morret, *administrative secretary*

Lilo V. Mueller, *administrative secretary*

Linda J. Unsworth, *adminstrative secretary*

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Megan E. Neuhard, *coordinator, group practice*

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Emily S. Ferguson, *administrative secretary*

Lianne M. Fickel, *membership clerk*

Sharon M. Sweigart, *membership clerk*

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Supports the activities of the Publications, Spring Assembly and Distinguished Service Award committees; coordinates media contacts and public affairs initiatives.

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Rachel A. Cromwell, *adminstrative secretary*

Linda M. Sholly, *administrative secretary*

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Renée R. Kessler, *assistant director, publication design*

Lorraine L. Rusinko, *advertising assistant*

Stacy J. Bolden, *desktop publishing operator/secretary*

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Media Relations

Amy K. Dugan, *director*

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Sandra L. Oravec, *director*

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Mildred A. Grimm, *receptionist*

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Susan M. Weber, *assistant general counsel*

Ellen W. Jones, *assistant general counsel, governmental affairs*

Mary E. Anderson, *administrative secretary*

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Terry A. Goodling, *telephone/word processing operator*

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Jennifer L. Bell, *records center clerk*

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Kenneth J. Cote, *senior programmer/ analyst*

Julie L. Hamman, *programmer/analyst*

Michael A. Drawbaugh, *programmer*

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Provides loans to medical and allied health students, students who are children of deceased and disabled physicians, and physicians establishing practice in underserved areas; develops professional educational materials; conducts marketing research on professional and public health issues; administers Physicians' Health Programs, The Institute for Physician Leadership, and the work of the Pennsylvania Diabetes Academy.

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Maureen G. Hoepfer, *marketing specialist*

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Juli C. McGreevy, *project associate*

June K. Mansberger, *administrative assistant*

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Gregory K. Gable, *associate director*

Madlyn K. Orloski, *coordinator, case management*

Wendie L. Dunkin, *administrative assistant*

Professional (Pennsylvania) Diabetes Academy

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Wendy I. Bixler, *administrative assistant*

Important Phone Numbers

Pennsylvania Medical Society

(717) 558-7750
(800) 228-7823
Fax: (717) 558-7830

American Medical Association

(800) AMA-3211

Pennsylvania State Government Offices

Numbers listed are for general information unless otherwise indicated.

Department of Aging
(717) 783-3126

Department of Health
(717) 787-5901
(800) 692-7254

Department of Insurance
(717) 787-2317

Department of Public Welfare Medical Assistance Physician Inquiries
(717) 782-6338
(800) 537-8862

Pennsylvania House of Representatives General Information
(717) 787-2372

Bill Status
(717) 787-2342

Pennsylvania Senate General Information and bill status
(717) 787-5920

Governor's Office
(717) 787-5962

Department of Transportation, Driver Qualifications
(717) 787-9662

Attorney General
(717) 787-3391

Consumer Protection Hot Line
(800) 441-2555

State Board of Medicine
(717) 787-2381
(717) 783-1400

Osteopathic Board of Medicine
(717) 783-4858

Pennsylvania Medical Society Affiliates

Pennsylvania Medical Society Liability Insurance Company

(717) 558-7500
(800) 445-1212

PAMPAC

(717) 558-7750

Keystone Peer Review Organization

(717) 564-8288

The Educational and Scientific Trust of the Pennsylvania Medical Society

(717) 558-7750

Alliance

(717) 558-7750

Insurance Companies Endorsed by the Pennsylvania Medical Society

Pennsylvania Medical Society Liability Insurance Company

(717) 558-7500
(800) 445-1212

Bertholon-Rowland Eastern PA
(800) 556-2500

Western PA
(800) 327-1550

The Dodson Group (workers' compensation)
(800) 825-3760, ext. 2990

Pennsylvania Blue Shield – Private Business

For claims information from Medical-Surgical and Vision Customer Service regional offices:

Central
(717) 731-8080

Eastern
(717) 975-7290

Western
(717) 975-5054

OASIS

(automated telephone response system):
800-462-7474

Harrisburg Area
(717) 975-6800

Electronic claims submission:
(717) 975-7130 (private business)
(717) 763-6722 (Medicare)

Pennsylvania Blue Shield District Offices, Professional Service and Review Representatives:

Central
(717) 731-2045

Eastern
(215) 564-2816

Western
(412) 471-7916

Ordering Forms:

Pennsylvania Blue Shield
Shipping Control Department
P.O. Box 890089
Camp Hill, PA 17089-0089
(717) 763-3256

Medicare

General information and claim status

(717) 763-5700

Automated Response Unit

(717) 730-8871

About your membership ...

Your membership in the Pennsylvania Medical Society supports a wide range of services and resources. These include:

- *continuous monitoring of legislation affecting the practice of medicine at the state and federal levels, experienced representation in public hearings and person-to-person meetings, and immediate action, when warranted, by physician Legislative Action Teams and Key Contacts.*
- *free help with reimbursement problems and questions through the Society's Reimbursement Resource Program, whose services include:*
  - *—advice regarding disputes with third-party payers*
  - *—Pennsylvania-specific reimbursement publications, and*
  - *—assistance in the development of medical and reimbursement policy with third-party payers.*
- *evaluation, development, and approval of Continuing Medical Education programs.*
- *two monthly publications,* Pennsylvania Medicine *and* Executive Report.
- *personal support services through the Physicians's Health Programs and through the educational, support, and student loan programs of The Educational and Scientific Trust.*
- *representation of physicians' interests in public health initiatives and activities.*
- *special publications, workshops, seminars, position papers, and other resources developed especially for Pennsylvania physicians. Topics include:*
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  - *—professional public relations and media relations activities, including editorial board visits, press releases, press conferences, responses to media reports, letters to the editor, and timely response to media inquires.*

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